

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 79-04861							
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR	
Hazel Nellie Allyn		Feb 13, 1979										4:00P <sub>M</sub>	
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		March 21, 1899		79		YRS		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH							
New York		USA				Prince George				MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Cheverly		Prince George's Gen'l Hosp				Housewife		Home					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
New York		Monroe		Churchville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				82 Fairbanks Road			
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NAME UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS			
Wallace		Nellie		Dix		No		078-30-9974		Ralph Allyn (son) Bowie, Md.			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Heavy Chain Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		7 years			
2732		DUE TO, OR AS A CONSEQUENCE OF		(b)				DUE TO, OR AS A CONSEQUENCE OF		(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)		Coronary Atherosclerosis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		CITY OR TOWN		COUNTY		STATE			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET									
22a. I certify that (I) (this hospital) attended the deceased from		JAN 15, 1978		to		FEB 13, 1979		that (I) (we) lost		saw the deceased alive on		FEB 13, 1979	
above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		Feb 15, 1979					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Nelson G. Goodman, M.D.		3231 Superior Lane A-7, Bowie, Md. 20715											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION		CITY OR TOWN		COUNTY		STATE	
Burial		Feb 17, 1979		Grove Place Cemetery		Chili		Monroe		N. Y.			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Francis Gasch's Sons, PA Hyattsville, Md.		FEB 21 1979		Anthony McCready									

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH				2b. HOUR			
FLORIAN W ANDERSON		FEBRUARY 19, 1979				6:45A M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		Black		12 24 1900		78		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA				Prince George's MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Lanham		Doctors' Hospital of Pr. Geo. Co.				Dining Car Waiter			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Seat Pleasant		PG		YES <input type="checkbox"/> NO <input type="checkbox"/>		6223 Addison Road	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
Charles Anderson		Madora Handy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT					
no		A578053620		6223 ADDISON RD. ELEANOR ANDERSON SEAT PLEASANT, MD 336-8844					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Lung Cancer</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>21 Jan</u> , 19 <u>79</u> , to <u>19 Feb</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>18 Feb 79</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
<u>Thomas A. Benning</u>		MD				2/20/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
THOMAS A. BENNINGER		831 University Blvd E S. 1 Spg 405 20803							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		2/23/79		Lincoln Memorial Cemetery		Suitland, Md.			
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Stewart Funeral Home-4001 Benning Road, NE.		FEB 26 1979							

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1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-04863

1. DECEASED NAME (TYPE OR PRINT) <b>VIRGIL R ANDERSON</b>		LAST		2a. DATE KNOWN OF DEATH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 02 04 19 79		2b. HOUR 9:45	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Jan 18, 1913</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>02 04 19 79</b>	7d. HOUR <b>AM</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kansas</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES</b> MD	
10. CITY OR TOWN OF DEATH <b>Laurel</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GREATER LAUREL BELTSVILLE HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Contractor</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Howard</b>	13c. CITY OR TOWN <b>Laurel</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>10095 Washington Blvd. N.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>David L. Anderson</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Murphy</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>512-16-1212</b>		17. INFORMANT ADDRESS <b>Ina M. Anderson same as #13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiac vascular disease</b> 429.3 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>Chronic bds fracture pulmonary disease</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>		M.D. TITLE (SPECIFY) <b>DEPUTY</b>		MEDICAL EXAMINER <b>12800 WILLOW WIND CIRCLE</b>		DATE SIGNED <b>2-4-79</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>AUGUSTO P. RODRIGUEZ</b>		ADDRESS <b>OXON HILL, MD 20022</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/7/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		23d. LOCATION (CITY OR TOWN) COUNTY STATE <b>Burtonsville, Mont. Md.</b>	
24. FUNERAL DIRECTOR <b>FLECK LAUREL FUNERAL HOME, INC.</b> <b>7601 Sandy Spring Rd. Laurel, Md. 20810</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 5 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Augusto P. Rodriguez</b>	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-04864

1. DECEASED-NAME (Type or print) <b>James Allan</b>			2a. DATE OF DEATH Month <b>FEB</b> Day <b>24</b> Year <b>1979</b>			2b. HOUR <b>4:27 PM</b>				
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>Feb. 21 1885</b>		6. AGE (In years lost birthday) <b>94</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Iowa</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Pr. Geo.</b>				
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>2600-Queens Chapel Road</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Ret. Optometrist -</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Optical Co.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Pr. Geo.</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2600-Queens Chapel Rd.</b>	
14. FATHER'S NAME First <b>James</b> Middle <b>Allan</b> Last <b>Ellen</b>			15. MOTHER'S MAIDEN NAME First <b>Ellen</b> Middle <b>M.</b> Last <b>McGregar</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>578-03-4201</b>		17. INFORMANT Address <b>Vergie L. Allan - above address</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF <b>CONGESTIVE HEART FAILURE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>GENERALIZED ARTERIOSCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>9 years</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 1</b> , 19 <b>70</b> , to <b>FEB 24</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>FEB 23</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Thomas F. Collins MD</b>			DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2-24-79</b>			
22d. PHYSICIAN'S NAME (Type) <b>THOMAS F. COLLINS MD</b>			22e. ADDRESS <b>2600 QUEENS CHAPEL RD</b>							
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>			23b. DATE <b>2/27/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem.</b>			23d. LOCATION (City or Town) (County) (State) <b>Brentwood Pr. Geo. Md.</b>		
24. FUNERAL DIRECTOR <b>Nalley's F.H. Inc.</b>			ADDRESS <b>St. Rainier, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 01 1979</b>			25b. REGISTRAR'S SIGNATURE <b>Henry McCreedy</b>		

12340-25

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-04865
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR
		FIRST MIDDLE LAST William A. Ash				MONTH DAY YEAR 2-19-79				6:10 p.m.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		8. UNDER 24 HRS.
Male		Black		MONTH DAY YEAR June 10, 1908		70 YRS.		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Virginia		U.S.A.				Prince George MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Riverdale		Leland Memorial Hospital				Construction				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Pr. Geo. Landover						YES <input type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST William Ash				FIRST MIDDLE LAST Susie Jackson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No						4935 Nash St. N.E. Corine Williams (Sister) Washington, D. C.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Acute cerebrovascular occlusion</u>										1 day
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Old cerebral infarct</u>										7-25-78
DUE TO, OR AS A CONSEQUENCE OF (c) <u>General arteriosclerosis and sequelae</u>										unknown
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION				
		HOUR A.M. MONTH DAY YEAR P.M. 19		[ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2]		CITY OR TOWN COUNTY STATE				
21e. INJURY OCCURRED		21f. PLACE OF INJURY		21g. LOCATION						
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		STREET						
22a. I certify that (I) (this hospital) attended the deceased from <u>November 22, 1975</u> , to <u>February 19, 1979</u> , that (I) (we) lost saw the deceased alive on <u>February 19, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE						DEGREE		22c. DATE SIGNED		
<u>Carl J. Houmann</u>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		2-20-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS				
Carl J. Houmann, M. D.						4404 Queensbury Rd., Riverdale, Md. 20840				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION				
Removal		2-22-79		Cartwright Funeral Home		CITY OR TOWN COUNTY STATE Winchester Va.				
24. FUNERAL DIRECTOR				25a. DATE RECEIVED BY REGISTRAR				25b. REGISTRAR'S SIGNATURE		
NAME George R. Snowden				246 N. Washington St. Rockville, Md. 20850				PLB 28 1973		

12-01862



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 79-04866	
1. DECEASED NAME (TYPE OR PRINT) <b>Clarence N. BAILEY</b>							2a. DATE KNOWN OF DEATH ESTIMATED <b>2/24 1979</b>		2b. HOUR <b>8:00</b>		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH (MONTH DAY YEAR) <b>8-9-09 69</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.	IF UNDER 1 YR. MONTHS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD <b>2/24 1979</b>		2d. HOUR <b>8:00</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.					
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince Georges Leon. Hosp. (DOA)</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Crane Operator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Lone Star Industries</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Pr. Geo.</b>		13c. CITY OR TOWN <b>Capitol Hts</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1204 Nova Avenue</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Bailey</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Coblenz</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>578-09-2796</b>		17. INFORMANT ADDRESS <b>Viola Christensen (dau) Morningside Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Certain selective cardiovascular disease</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Emaciation, Chronic obstructive pulmonary disease, Hepatic cirrhosis</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>			TITLE (SPECIFY) <b>Deputy</b>			MEDICAL EXAMINER		DATE SIGNED <b>1-25-79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez</b>			ADDRESS <b>17800 W. Highland Circle, Suitland Md. 21088</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>28Feb1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Suitland</b> COUNTY <b>Pg</b> STATE <b>Md.</b>				
24. FUNERAL DIRECTOR NAME <b>Robert E. Wilhelm</b> ADDRESS <b>Funeral Home</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 01 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert E. Wilhelm</b>					

12-04888



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the undertaker, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-04867	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Shirley Marie Baker</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>Fwb 21, 1979</b>		2b. HOUR <b>1:01P</b> M	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb 12, 1929</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>50</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b> MD.					
10. CITY OR TOWN OF DEATH <b>Lanham</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Pr. Geo's Doctors Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Pr. Geo's</b>		13c. CITY OR TOWN <b>Lanham</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5610 Lanham Station Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Henry Simmons</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Kane</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>578 38 3763</b>		17. INFORMANT ADDRESS <b>James C Baker Lanham, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>496-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>above &amp; obstructed lung disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
21g. I certify that (I) (this hospital) attended the deceased from <b>Jan 16, 1979</b> to <b>2-21</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>2-21</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <b>J. Richard Lilly</b> DEGREE _____				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. Richard Lilly</b>				22e. ADDRESS <b>Hyattsville, Md</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb 24, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood Pro Georges Md.</b>			
24. FUNERAL DIRECTOR NAME <b>F. Gasch's Sons P A Hyattsville, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 26 1979</b>				25b. REGISTRAR'S SIGNATURE <b>Ruby McCready</b>			

70-04887

RECEIVED  
JAN 11 1950  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]

RE: [Illegible]  
[Illegible]

DATE: [Illegible]  
[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-04868

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
MARIE			BARRETT	BALON	02 13 79					10:12A.M.	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		Caucasian		12 14 10		68		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH				MD.	
Pennsylvania		USA				PRINCE GEORGES					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Clinton		SOUTHERN MARYLAND HOSPITAL CENTER		Retired - Clerk		US Gov't					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.		Pr. Geo.		Oxon Hill		YES <input type="checkbox"/> NO <input type="checkbox"/>		3419 Stonesboro Road			
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST				FIRST MIDDLE LAST							
William Barrett				C Bittenbender							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)				17 INFORMANT ADDRESS			
No				199 32 2392				Marie Joan Horne 3419 Stonesboro Rd Oxon Hill, Maryland			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a): <i>Metastatic carcinoma</i>											
1991											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b):											
DUE TO, OR AS A CONSEQUENCE OF											
(c):											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
<i>herdier pathologic right femur</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>2-7</u> , 19 <u>79</u> , to <u>2-13</u> , 19 <u>79</u> , that (I) (we) lost											
saw the deceased alive on <u>2-13</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>C. D. Dilallo</i>				DEGREE				22c. DATE SIGNED			
								2/13/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Chester A. Dilallo				9131 Piscataway Road Clinton Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		2-16-1979		Calvary Cemetery		Luzerne Cty Drums Penna					
24 FUNERAL DIRECTOR'S NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Robert E Wilhelm Funeral Home Suitland Maryland				FEB 22 1979				<i>Robert E Wilhelm</i>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

79-04888

US Const - Clerk

Attendant

302 State Land House 3415 Lombard St  
Green Hill, Maryland

9131 Pleasantway Road Clinton Maryland

Serial 2-16-1979 Delivery Company  
Robert D. Williams General Home  
Cecil and Maryland

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04869

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Willard Wayne BEAVERS</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>1/30/79</b>		2b. HOUR <b>3:07aM</b>	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5/20/39</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>39</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 74 HRS HOURS MIN.	
7a. BIRTH COUNTRY <b>Wash. D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Pr. Georges</b> MD.		10. CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Maryland Hospital</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Policeman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>P.G. County Gov't</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b>		13b. COUNTY <b>Pr. Georges</b>		13c. CITY OR TOWN <b>Brandywine</b>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt. 3 Box 437</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Willard Linton Beavers</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Harriet Margarite Simmons</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>Vietnam 213-38-0521</b>		17. INFORMANT ADDRESS <b>Wife Marilyn H. Beavers same as 9</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>4275</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>9</b> 19 <b>70</b> to <b>1-29</b> 19 <b>79</b> , that (1) (we) lost saw the deceased alive on <b>1-29</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Rafael Lee</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1-30-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Rafael Lee</b>		22e. ADDRESS <b>Clinton, Md</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Bural</b>		23b. DATE <b>2-1-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Croom, P.G., Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Heart Funeral Home, St. Michaels, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 5 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Barney McCreedy</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 of the certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

29

BP

00840-01

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 79-04870	
1. FOR STATE REGISTRAR										2a. DATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Deborah J. BEIRNE</i>										2b. HOUR <i>12</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>3-23-61</i>		6. AGE (IN YEARS) LAST BIRTHDAY YRS. <i>17</i>		7. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>2-9-79</i>		2c. HOUR <i>12</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Texas</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i>		10. CITY OR TOWN OF DEATH <i>Cheverly</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prince Georges Hosp</i>	
12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> 13b. COUNTY <i>Prince Georges</i> 13c. CITY OR TOWN <i>Bowie</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>4900 Rocky Spring Lane</i>		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Student</i>		12c. KIND OF BUSINESS OR INDUSTRY			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Raymond A. Beirne</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Irma J. Juhasz</i>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>212-68-2068</i>	
17. INFORMANT <i>Raymond A. Beirne</i>				ADDRESS <i>Same as # 13</i>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:				IMMEDIATE CAUSE (a) <i>Sepsis</i>				DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.				(b) <i>Multiple traumatic injuries</i>				DUE TO, OR AS A CONSEQUENCE OF			
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION <i>1-6-79</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Exploratory laparotomy &amp; splenectomy</i>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
19c. DATE OF OPERATION <i>1-18 &amp; 22/79</i>				19d. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Right thoracotomy &amp; right craniotomy</i>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>1035 P.M. 1-5 1979</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Passenger in two car collision</i>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Street</i>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>16400 Blk Annapolis Rd, Bowie, Md. Geo.</i>			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>August P. Proden</i>				TITLE (SPECIFY) <i>Deputy</i>				DATE SIGNED <i>2-9-79</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>August P. Proden</i>				ADDRESS <i>1200 Wilton Wood Circle, Tanawana</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>2-15-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart Ch. Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Bowie Pr. Geo. Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Robert G. Beall</i>						ADDRESS <i>9013 Annapolis Rd. Lanham, Md. Vince</i>		25a. DATE REC'D. BY REGISTRAR <i>FEB 15 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Robert G. Beall</i>	

07840-05





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>Ernest Preston</i>										MIDDLE <i>BELCHER</i>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 2-22 1979		2b. HOUR M	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>5-12-08</i>		6. AGE (IN YEARS) LAST BIRTHDAY YRS. <i>70</i>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD <i>2-22 1979</i>		2d. HOUR M									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Va.</i>				7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore</i>				MD							
10. CITY OR TOWN OF DEATH <i>Cheverly</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Pr. Geo. Gen. Hosp.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Ret. Auto mechanic</i>				12b. KIND OF BUSINESS OR INDUSTRY											
13a. STATE <i>Md.</i>										13b. COUNTY <i>Pr. Geo.</i>		13c. CITY OR TOWN <i>Cap. Heights</i>		13d. STREET ADDRESS <i>1308 - Lanchmont</i>		13e. CITY OR TOWN <i>Cap. Heights</i>							
14. FATHER'S NAME FIRST MIDDLE LAST <i>Albert S. Belcher</i>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Nancy Adams</i>													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>no</i>				16b. SOCIAL SECURITY NO. <i>225-10-7348</i>				17. INFORMANT ADDRESS <i>Albert L. Belcher - same as above</i>															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intense chronic cardiovascular disease</i> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>Cheney</i>																							
19a. DATE OF OPERATION <i>Cheney</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) <i>Deputy</i>				MEDICAL EXAMINER				DATE SIGNED <i>2-22-79</i>											
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez</i>				12800 Willow Wind Circle, Oxon Hill, Md. 20022																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>				23b. DATE <i>2-27-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Crematory</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Brentwood Pr. Geo. Md.</i>													
24. FUNERAL DIRECTOR NAME ADDRESS <i>Nalley's F.H. Inc. Mt. Rainier, Md.</i>										25a. DATE REC'D. BY REGISTRAR <i>MAR 01 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Henry McCready</i>											

17340-0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG NO 79-04872			
1. FOR STATE REGISTRAR						2a. DATE OF DEATH MONTH DAY YEAR						2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST						02 01 79						6:10A.M.	
JAMES KARL BRINEGAR													
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN.			
Male		Caucasian		12 19 36		42 YRS							
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH							
W. Virginia		U.S.A.				Prince Georges MD.							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Clinton		SOUTHERN MARYLAND HOSPITAL CENTER				Iron Worker		Construction					
13a. STATE						13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			
Md.						Charles		Waldorf		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Lorenzo D. Brinegar						Lucinda Parsons							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)						16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
Yes						1956-1959		236-56-2265 Sharon L. Brinegar Waldorf, Maryland					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 MALIGNANT PERICARDIAL EFFUSION DUE TO (b) AS A CONSEQUENCE OF METASTATIC EPIDERMOID CARCINOMA OF (c) LUNG										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
										3 WKS			
										1/2 YR			
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I (the hospital) attended the deceased from 9/9 1978 to 2/1 1979, that (we) lost the deceased alive on 1/31 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.													
22b. SIGNATURE						DEGREE		22c. DATE SIGNED					
James A. Brown, MD								2/1/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS							
James A. Brown, MD						625 Belcrest Rd. Hyattsville, MD 20782							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial				2/5/79		Cheltenham Vet. Cem.		Cheltenham Prince Georges Maryland					
24 FUNERAL DIRECTOR NAME						ADDRESS		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE					
George P. Kalas Funeral Home						6160 Oxon Hill Rd. Oxon Hill, Md.		FEB 6 1979					

10-01815

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 79-04873
1. DECEASED NAME (TYPE OR PRINT) <i>Francis A. BROWN</i>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <i>2-12-79</i>		2b. HOUR <i>M</i>		
3. SEX <i>Male</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>9-14-13</i>		6. AGE (IN YEARS) LAST BIRTHDAY <i>65</i> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>2-12-79</i>		7d. HOUR <i>M</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD.				
10. CITY OR TOWN OF DEATH <i>Chesley</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prince Geo. General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST WORKING LIFE) <i>RETIRED - GOV.</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> 13b. COUNTY <i>Pr-George</i> 13c. CITY OR TOWN <i>St. Georges</i>						13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>6315 Carrington Court</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Robert B. Brown</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Somerville</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Yes</i> (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. <i>578-16-5832</i>		17. INFORMANT <i>6315-Carrington Court DOROTHY BROWN - wife</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic pulmonary cardiac vascular disease</i> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>Branches general carcinoma</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion										
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) <i>M.D.</i>		MEDICAL EXAMINER		DATE SIGNED <i>2-12-79</i>		
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez</i>				ADDRESS <i>12800 Wilkerson Ave. Suite 100, Takoma Park, MD 20912</i>						
23a. BURIAL, CREMATION, REMOVAL, DATE <i>Burial 2/15/79</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Resurrection Cemetery</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Clinton, Maryland</i>		
24. FUNERAL DIRECTOR NAME <i>John T. Stewart III</i> ADDRESS <i>Funeral Home-4001 Benning Road, NE.</i>				25a. DATE REC'D. BY REGISTRAR <i>FEB 21 1979</i>		25b. REGISTRAR'S SIGNATURE <i>John T. Stewart III</i>				

25.55



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 79-04874			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GARLAND R. BROWN				2a. DATE OF DEATH MONTH DAY YEAR 2 7 79			
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 1 16 10		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hyattsville, P.D. MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bindery Opr.		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
13a. STATE D.C.		13b. COUNTY		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Brown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Simms		13e. STREET ADDRESS 3701 16th St., N.W. # 208			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 1 1		17. INFORMANT ADDRESS Louise D. Doy 4917 Fitch Pl., N.E. Wash., D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 185- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adenocarcinoma of prostate &amp; Metastases</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Prothemia, Anemia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) A.S.N.D.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/27/79 to 2/21/79, 19 79, that (I) (we) last saw the deceased alive on 1/24/79, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE (Signature) DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V.C. Voial M.D.				22e. ADDRESS 7676 New Hampshire Ave			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 13 Feb. 79		23c. NAME OF CEMETERY OR CREMATORY Lincoln Mem. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland	
24. FUNERAL DIRECTOR NAME John F. Pollock				ADDRESS 7400 Ga. Ave., N.W. Washington, D.C.		25a. DATE REC'D. BY REGISTRAR FEB 13 1979	
25b. REGISTRAR'S SIGNATURE (Signature)							

10-04874

10-04874

20% EDITION

20% EDITION





**RETURN TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

**RETURN TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene in order to burial, cremation, or removal.

**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-04875 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Grace M. Brown						2a. DATE OF DEATH MONTH DAY YEAR 2 1979			2b. HOUR 12:45 AM				
3. SEX F		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 2 25 94		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD							
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) American Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housework			12b. KIND OF BUSINESS OR INDUSTRY -----				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md						13b. COUNTY Charles		13c. CITY OR TOWN La Plata		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 301 20646	
14. FATHER'S NAME FIRST MIDDLE LAST Philmore						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN Wells							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 219-48-2869		17. INFORMANT ADDRESS Charles Co., MD. Viola Queen Carvan Motel-169 White Plains									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 4379 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral Vascular Insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Recent													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Anemia - Polycythemia													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 3/29, 1976, to 2/19, 1979, that (I) (we) last saw the deceased alive on 2/18, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE R. M. Brown, M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/19/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) 4235 28th Ave md 21222						22e. ADDRESS Rt 201 MOUNTAIN, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 26, 1979		23c. NAME OF CEMETERY OR CREMATORY Shiloh United Meth.				23d. LOCATION CITY OR TOWN COUNTY STATE Newburg Charles, MD.					
24. FUNERAL DIRECTOR NAME ADDRESS Thompson's Funeral Home Pomonkey, Md.						25a. DATE REC'D. BY REGISTRAR FEB 28 1979		25b. REGISTRAR'S SIGNATURE Antony DeBuddy					

13-04812

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION



RECEIVED

APR 11 1964

APR 11 1964

TO DIRECTOR, FBI (100-441111) FROM SAC, NEW YORK (100-100000) (P)

RE NEW YORK TELETYPE TO BUREAU, APRIL TEN LAST.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

#8 per counter, with Funeral Home STATE OF MARYLAND  
2/15/79 gj  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1- STATE REGISTRAR

REG. NO. 79-04876

1 DECEASED NAME (TYPE OR PRINT) <b>JOSEPH A. BROWN</b>			2a. DATE OF DEATH MONTH <b>01</b> DAY <b>29</b> YEAR <b>79</b>		2b. HOUR <b>9:30 PM</b>
3 SEX <b>Male</b>	4 RACE <b>Negro</b>	5. DATE OF BIRTH MONTH <b>08</b> DAY <b>2</b> YEAR <b>1911</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S MD.</b>		
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGE'S GENERAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md.</b>			13b. COUNTY <b>Pr. Geo.</b>	13c. CITY OR TOWN <b>Upper Marl</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST <b>John W.</b> MIDDLE <b>Brown</b> LAST <b></b>			15. MOTHER'S MAIDEN NAME FIRST <b>Bessie E.</b> MIDDLE <b>Quander</b> LAST <b></b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-12-7240A</b>	17 INFORMANT ADDRESS <b>Christine Johnson 5301 Spring Dr. Upper Marlboro, Md.</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RECENT BILATERAL PULMONARY EMBOLISM</b> <b>4151</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>19 1</b> to <b>29</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>1 29</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Hanan A. Molavi, M.D.</b> DEGREE				22c. DATE SIGNED <b>1.30.79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>H. A. MOLAVI, M.D.</b>				22e. ADDRESS <b>6005 Landover Rd Chevy, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/2/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cem.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clinton P.G. Md.</b>		23e. DATE REC'D. BY REGISTRAR <b>FEB 6 1979</b>			
24 FUNERAL DIRECTOR NAME <b>Adams Funeral Home</b>		ADDRESS <b>Capascon, Md</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony A. [Signature]</b>	

BP

79-04876

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-04877	
1. FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret Buckner				2a DATE OF DEATH MONTH DAY YEAR 2/24/79		2b HOUR 6:15 A M			
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 5 14 07		6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County, MD.					
10 CITY OR TOWN OF DEATH Greenbelt, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greenbelt Convalescent Center				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Grocer		12b KIND OF BUSINESS OR INDUSTRY Grocery Store			
13a. STATE Md.		13b. COUNTY Prince Georges		13c. CITY OR TOWN College Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6100 Westchester Park Drive			
14 FATHER'S NAME FIRST MIDDLE LAST John Breckenridge Buckner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Allie Blackstone White		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 227-14-8023		17 INFORMANT ADDRESS Bertie Pettit 5502 Emerson Street Hyattsville, Maryland			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>Myocardial Infarction</u> 1978									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Month		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Myocardial Infarction</u> 1978											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from 1/9 1979 to 2/24 1979, that (1) (we) last saw the deceased alive on 2/22 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE A. Achachito				DEGREE M.D.				22c. DATE SIGNED 2/24/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Greenbelt Professional Center				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 27, 1979		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Bowling Green-Caroline Co.-Va.					
24 FUNERAL DIRECTOR NAME W.W. CHAMBERS CO.				24b. ADDRESS RIVERDALE MARYLAND		25a. DATE REC'D. BY REGISTRAR FEB 28 1979					
25b. REGISTRAR'S SIGNATURE [Signature]											

77840-01



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-04878

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>CATHERINE B. BURKE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>FEB 22 1979</b>			2b. HOUR <b>5<sup>45</sup> A M</b>	
3 SEX <b>Female</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>07 21 91</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Alex VA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES MD.</b>	
10. CITY OR TOWN OF DEATH <b>Adelphi M.D.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Manor Care Adelphi</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Plumber</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Arthur C. THOMAS XXXXXXXX</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELLA CREEGAN</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>578-34-3615</b>	
17. INFORMANT <b>ROBERTA A. BURKE</b>		17. ADDRESS <b>SAME AS 13 DAUGHTER</b>		17. STREET ADDRESS <b>5523 HALPINE PLACE, APT 102</b>		17. CITY <b>ROCKVILLE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Disease</b> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerosis, general</b> (c) <b>Release body</b>		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>June 60</b> to <b>Feb 22 1979</b> , that (I) (we) last saw the deceased alive on <b>Feb 21</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>John F. Brennan M.D.</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>Feb 23 1979</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN F. BRENNAN</b>		22e. ADDRESS <b>3415 HAMILTON ST, HYATTSVILLE, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>2/24/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET</b>		23d. LOCATION CITY COUNTY STATE <b>WASHINGTON, D. C.</b>	
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>		ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 27 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

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78-0-01878

PRINCE GEORGE

U.C.A.

ALBANY

WINTHROP

C. THOMAS

ELL

JOHN J. JOHNSON

C. THOMAS

NO

THIS IS A COPY OF THE ORIGINAL RECORD

THIS IS A COPY OF THE ORIGINAL RECORD

THE STATE OF NEW YORK

IN SENATE

FRANCIS J. COLLINS

THE SENATE OF THE STATE OF NEW YORK

TO HOSPITAL, ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-04879	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EMILIE J. <i>Calis</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>February 24 1979</i>		2b. HOUR <i>4:30 PM</i>			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEB 21, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) JERUSALEM		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.					
10. CITY OR TOWN OF DEATH HYATTSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5912 ROSEDALE DRIVE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND		13b. COUNTY PRI. GEO		13c. CITY OR TOWN HYATTSVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5912 ROSEDALE DRIVE			
14. FATHER'S NAME FIRST MIDDLE LAST ISSA HABASH				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CELESTE MANTOURA							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS ODILE C. CARMi, SAME AS 13 DAUGHTER							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Respiratory Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Bronchopneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>A.S.N.D. = Congestive Cardiac Failure</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <i>Carcinoma, Vagina, C.O.P.D</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>2/24</i> , 19 <i>79</i> , to <i>2/24</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>2/24</i> , 19 <i>79</i> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) (we) ( <del>did not</del> ) view the body after death.											
22b. SIGNATURE <i>[Signature]</i>				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>2/25/79</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Vivik C. VAID				22e. ADDRESS 7676 New Hampshire Ave Hyattsville Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2/27/79		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.					
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR FEB 27 1979		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					
500 UNIV. BLVD., W. SILVER SPRING, MD. 20901											

REPORT OF THE

COMMISSIONER OF THE

LAND OFFICE

TO THE

LEGISLATIVE

COMMITTEE

ON

LANDS

AND

WATER

RESOURCES

OF THE

STATE

1911

REPORT

OF

THE

COMMISSIONER

OF THE

LAND OFFICE

TO THE

LEGISLATIVE

COMMITTEE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. <b>79-04880</b>	
1. DECEASED NAME (TYPE OR PRINT) <b>Kathy E CAIN</b>						2a. DATE KNOWN OF DEATH ESTIMATED <b>2-2 1979</b>				2b. HOUR <b>M</b>					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1-20-59</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>20 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD <b>2-2 1979</b>		2d. HOUR <b>19A</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b>					
10. CITY OR TOWN OF DEATH <b>Chesley</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince Georges General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Stock clerk</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Merchandise</b>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Pr. George</b>				13c. CITY OR TOWN <b>Richie</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>9405 Chestnut Park Street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Dewey Redden</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Erma Brooks</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>219-72-5681</b>				17. INFORMANT <b>Richard W. Cain</b>				ADDRESS <b>Same as #13 a-e.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple injuries with cerebral hemorrhages</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR AM MONTH DAY YEAR <b>8:30 P.M. 1/23 1979</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Vehicle to stationary object</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Street</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Driverhouse Road, Upper Marlboro, Pr. George</b>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <b>August P. Rodriguez</b>				TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER				DATE SIGNED <b>2-2-79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>August P. Rodriguez</b>				ADDRESS <b>12800 Wood Wind Circle, Oxon Hill</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Feb. 5, 1979</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cem.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clinton PR. George Md.</b>			
24. FUNERAL DIRECTOR <b>Shirley H. Simmons</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 15 1979</b>				25b. REGISTRAR'S SIGNATURE <b>notary McCurdy</b>							
6633 Old Alexander Ferry Rd. Clinton, Md.															

19-04880

RECEIVED  
FEB 10 1964  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

CONFIDENTIAL

Washington, D.C., 20535

TO: DIRECTOR, FBI (100-441100) FROM: SAC, NEW YORK (100-100000)

SUBJECT: JAMES EARL RAY; AKA; ALIASES; FUGITIVE; MURDER OF MARTIN LUTHER KING, JR.

RE: NEW YORK TELETYPE TO BUREAU, FEBRUARY NINE, SIXTYFOUR.

ON FEBRUARY EIGHT, SIXTYFOUR, AN INDIVIDUAL IDENTIFIED HIMSELF AS

JOHN EDGAR HOOVER, JR., AND STATED THAT HE WAS THE SON OF THE

DIRECTOR OF THE FEDERAL BUREAU OF INVESTIGATION.

HE STATED THAT HE HAD INFORMATION CONCERNING THE WHEREABOUTS OF

JAMES EARL RAY, WHO HE CLAIMED WAS CURRENTLY IN THE UNITED STATES.

HE REQUESTED ASSISTANCE IN LOCATING RAY AND OFFERING HIMSELF AS A

WITNESS IN ANY PROSECUTION.

HE STATED THAT HE HAD BEEN IN CONTACT WITH AN INDIVIDUAL WHO

HE BELIEVED WAS RAY, AND THAT HE HAD BEEN ADVISED THAT RAY WAS

PLANNING TO VISIT NEW YORK CITY.

HE REQUESTED THAT THE BUREAU BE KEPT ADVISED OF ANY DEVELOPMENTS.

VERY TRULY YOURS,  
J. Edgar Hoover, Director

Enclosure

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-04881	
1. FOR STATE REGISTRAR										2a. DATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William L. Cann Sr										MONTH DAY YEAR February 5, 1979	
2b. HOUR 2:00 p/m											
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Mar. 7, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.					
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U S Government		12b. KIND OF BUSINESS OR INDUSTRY Lawyer			
13a. STATE Md		13b. COUNTY Pro Georges		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3902 Longfellow st			
14. FATHER'S NAME FIRST MIDDLE LAST William Lewis Cann					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Netta Kershaw						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578 26 8325		17. INFORMANT ADDRESS William L Cann Jr Hyattsville, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 4392 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which } (b) Arteriosclerotic cardiovascular disease gave rise to immediate } cause (a), stating the } underlying cause last } (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Three days Unknown	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from January 12, 1977, to February 5, 1979, that (I) (we) last saw the deceased alive on February 4, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Carl J. Houmann						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-5-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Carl J. Houmann, M. D.						22e. ADDRESS 4404 Queensbury Road, Riverdale, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb 7, 1979		23c. NAME OF CEMETERY OR CREMATORY Methodist-Episcopal		23d. LOCATION CITY OR TOWN COUNTY STATE Marshalltown Chester Pa					
24. FUNERAL DIRECTOR NAME F. Gasch's Sons P A Hyattsville, Md ADDRESS						25a. DATE REC'D. BY REGISTRAR FEB 8, 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

29

BP 6180

18840-97



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-04882

REG. NO.

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>DONALD - CANTOR</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 3 1979</b>			2b. HOUR a <b>11:05 M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 15, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Lanham, Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Doctors' Hospital of P.G. County</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Owner (Ret)</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Pearl String</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Pr. Geo.</b>		13c. CITY OR TOWN <b>Suitland</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET ADDRESS <b>3513 Silver Park Drive</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry - - - - - Cantor</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mollie - - - - - Browner</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>117-09-9702</b>		17. INFORMANT ADDRESS <b>Suitland, Md. Frieda Cantor, 3513 Silver Park Drive</b>			
18. CAUSE OF DEATH (Enter only one cause per line for 101, 102, and 103.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> <b>4410</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Declining Abdominal Aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arterio Sclerotic Cardio Vascular Disease</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 3</b> , 19 <b>78</b> , to <b>Feb 3</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>Feb 3</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Benjamin Pecson</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3 Feb 79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BENJAMIN PECSON, M., D.</b>						22e. ADDRESS <b>6106 Old Silver Hill Rd., Parkland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>2-4-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>National Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Falls Church, Va.</b>		
24. FUNERAL DIRECTOR NAME <b>Danzansky-Goldberg chapels</b>						ADDRESS <b>Rockville, Md. 1170 Rockville Pike</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 8, 1979</b>	
25b. REGISTRAR'S SIGNATURE <b>Anthony McCready</b>									

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

SB010-25

ALL INFORMATION CONTAINED

HEREIN IS UNCLASSIFIED

DATE 07-11-2001 BY 1043

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-04883	
1- FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST C. AND JULIA E. CARD				2a. DATE OF DEATH MONTH DAY YEAR 2 27 79		2b. HOUR 3:45 P M			
3. SEX F		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 3 31 1900		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Pr. Geo. MD					
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pr. Geo. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Beautician-Self Employed		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Mt. Rainier		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4209 - 28th St.			
14. FATHER'S NAME FIRST MIDDLE LAST Roman Bishop				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julianne Forr							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS Ethel A. Post - College Park, Md.		9026- 49th Ave.,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LEAD PNEUMONIA</u> 4340 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Thrombosis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Currency Artery Disease</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>6-7-78</u> , 19 <u>78</u> , to <u>2-27</u> , 19 <u>79</u> , that (I) (we) lost the deceased above on <u>2-27</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>K. J. MATHew</u> DEGREE				22c. DATE SIGNED <u>2/28/79</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. J. MATHew				22e. ADDRESS <u>3700 EIGHT WEST HWY HYATTSVILLE MD 21762</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/1/1979		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.					
24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc.		ADDRESS Mt. Rainier, Md.		DATE REC'D. BY REGISTRAR MAR 5 1979		25b. REGISTRAR'S SIGNATURE					

BP

19-04883

Handwritten notes and stamps, including "RECEIVED" and "JAN 19 1964".

RECEIVED  
JAN 19 1964

Handwritten notes and stamps, including "RECEIVED" and "JAN 19 1964".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/73  
(VRA 15 (4))1. FOR  
STATE  
REGISTRAR

# STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

79-04884

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Kathleen F. Carpenter</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>02-27-79</b>			2b. HOUR <b>2:30P M</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 27 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b>		7. IF UNDER 1 YEAR MONTHS DAYS YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W.Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George County MD.</b>				
10. CITY OR TOWN OF DEATH <b>Lsured</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater Laurel Beltsville Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Paper Mill</b>		
13a. STATE <b>Md.</b>			13b. COUNTY <b>Ann Arundel</b>		13c. CITY OR TOWN <b>Laurel</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Carpenter</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nellie Van Pelt</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>217 05 0456</b>		17. INFORMANT NAME ADDRESS <b>Delores Carpenter Laurel Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coma - Sec. to Uremic Encephalopathy</b> <b>5847</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Uremia - acute renal Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute medullary necrosis &amp; papillitis</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e.g., <b>Diabetes Mellitus, with acute hyperosmolar coma</b> )										
19a. DATE OF OPERATION <b>2-27-79</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Acute renal failure</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>2:30 P.M. 2-27 19 79</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>2-26-79</b> to <b>2-27-79</b> , that (I) (we) lost saw the deceased alive on <b>2-26-79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>J. JEN C. MARIANO M.D.</b>			DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>2-27-79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. JEN C. MARIANO</b>			22e. ADDRESS <b>3450 Rt Hensley Rd #209 Laurel Md 20810</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3/2/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Philos Cemtery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Westernport Allegany Md</b>		
24. FUNERAL SERVICE <b>Boal's Funeral Service, Westernport, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 5 1979</b>		25b. REGISTRAR'S SIGNATURE <b>H. H. H. H.</b>		

MEDICAL CERTIFICATION

TO THE SECRETARY OF THE ARMY

WASHINGTON, D.C.

DEAR SIR:

I have the honor to acknowledge the receipt of your letter of the 10th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully, your obedient servant.

Very truly yours,

John D. Smith

Major General, U.S. Army

Washington, D.C.

Enclosed for you are two copies of the report of the Committee on the subject of the proposed change in the regulations governing the appointment of officers to the grade of Major General.

I am, Sir, very respectfully, your obedient servant.

Very truly yours,

John D. Smith

Major General, U.S. Army

Washington, D.C.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17 20M 1/73  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC. NO. 79-04885

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ALVARIS DELON CARTER</b>		2a. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>2-9 1979</b>		2b. HOUR <b>M</b>	
3. SEX <b>MALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>1-2-34</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>45</b> YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD <b>2-9 1979</b>	7d. HOUR <b>4:30</b> M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES</b> MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince Georges Comm. Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Unk.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>District Hts</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Carter</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Carolyn Ellis</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>181-22-5783</b>	
17. INFORMANT ADDRESS <b>Adrienne A. Brox/daughter/3006 12th St.,</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTEROSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		TITLE (SPECIFY) <b>DEPUTY</b> M.D.		MEDICAL EXAMINER		DATE SIGNED <b>2-9-79</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>AUGUSTO P. RODRIGUEZ M.D.</b>		ADDRESS <b>12800 WILLOW WIND CIRCLE, TANTALLON, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2-17-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>John T. Rhines Co., 3015 12th St., N.E., D.C.</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 16 1979</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M/7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-04886  
REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Fannie Letta CARTER</i>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2-6 1979		2b. HOUR M					
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR 5-16-14		6. AGE (IN YEARS) LAST BIRTHDAY 64 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2-6 1979		2d. HOUR M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>ARKANSAS</i>				7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prime Georges</i> MD					
10. CITY OR TOWN OF DEATH <i>Chesapeake</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prime Georges Gen. Hosp. (DCA)</i>								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>RETIRED</i>				12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>D. C.</i> 13b. COUNTY <i>WASHINGTON</i>										13c. CITY OR TOWN <i>WASHINGTON</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>3017 Clinton Street, N. E.</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Brook F. Adams</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Etta Brown</i>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>579-18--0801</i>				17. INFORMANT ADDRESS <i>3017 Clinton St. N.E., Wash., D.C.</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <i>4393</i> IMMEDIATE CAUSE (a) <i>Coronary atherosclerotic - cerebrovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Chronic Obstructive pulmonary disease</i>																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE <i>August P. Rodriguez</i>				TITLE (SPECIFY) <i>Deputy</i>				MEDICAL EXAMINER				DATE SIGNED <i>2-6-79</i>					
EXAMINER'S NAME (TYPE OR PRINT) <i>August P. Rodriguez</i>				ADDRESS <i>12800 Wilkes Road Centre, Oak Hill Md 20892</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>				23b. DATE <i>2-9-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>GATE OF HEAVEN CEMETERY</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>WHEATON, MARYLAND</i>							
24. FUNERAL DIRECTOR NAME ADDRESS <i>John T. Rhines Co., 3030-12th-Street, N.E., DC</i>										25a. DATE REC'D. BY REGISTRAR <i>FEB 13 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Mary McCreedy</i>					

00840-01

RECEIVED  
MEDICAL EXAMINER  
JAN 10 1964

Family No. 1010

Date 1-10-64

(1010-1010)

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18840-01

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-04888

1. DECEASED NAME (Type or print) <b>Antimo</b>		First <b>Chiaccheiri</b>		Middle <b>Chiaccheiri</b>		Last <b>Chiaccheiri</b>		2a. DATE OF DEATH Month <b>2/7/79</b> Day <b>79</b> Year <b>1979</b>		2b. TIME OF DEATH <b>5:30 PM</b>	
3. SEX <b>M</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>2/28/02</b>		6. AGE (In years last birthday) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS <b>76</b> DAYS <b>76</b>		IF UNDER 24 HRS. HOURS <b>76</b> MIN. <b>76</b>	
7a. BIRTHPLACE (State or foreign country) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b>					
10. CITY OR TOWN OF DEATH <b>Oxon Hill</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>8440 Fort Foot Rd.</b>		12a. USUAL OCCUPATION (Kind of work done during last of working life, even if retired.) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Oxon Hill</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>8440 Fort Foot Rd.</b>			
14. FATHER'S NAME First <b>Camillo Chiaccheiri</b>				Middle <b>Chiaccheiri</b>				Last <b>Chiaccheiri</b>			
15. MOTHER'S MAIDEN NAME First <b>Maria D. Mitino</b>				Middle <b>Mitino</b>				Last <b>Mitino</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>285-10-1140A</b>		17. INFORMATION <b>9705 Indian Principis Dr. Oxon Hill</b>		17b. ADDRESS <b>Andrew A. Chiaccheiri Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest</b> <b>1889</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Transitional cell carcinoma of bladder</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>1 yr</b> <b>1 yr.</b>										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>---</b>	
19a. DATE OF OPERATION <b>---</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>---</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>---</b>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b>19</b> Month <b>19</b> Day <b>19</b> Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>---</b>							
21d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <b>---</b>		21f. LOCATION Street or R.F.D. No. <b>---</b> City or Town <b>---</b> County <b>---</b> State <b>---</b>							
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 1970</b> to <b>2/7 1979</b> , that (I) (we) lost the deceased alive on <b>2-7-1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Michael G. Corrado</b>		DEGREE <b>---</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2/8/79</b>							
22d. PHYSICIAN'S NAME (Type) <b>Michael A. Corrado</b>		22e. ADDRESS <b>2946 Sleepy Hollow Rd, F.C., Va</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2/10/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Brentwood, P.G. Md.</b>					
24. FUNERAL DIRECTOR <b>The Funeral Home Inc.</b>		ADDRESS <b>6633 Old Alexander Ferry Rd. Clinton Md</b>		25a. REC'D BY REGISTRAR <b>FEB 15 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia McCreedy</b>					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										79-04889 REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Alice J. Christopher						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 2 20 19 79		2b. HOUR M			
3. SEX female		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 4-12-1931		6. AGE (IN YEARS) LAST BIRTHDAY 47 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD 2 20 19 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George County MD.					
10. CITY OR TOWN OF DEATH Cherverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY n/a			
13a. STATE Maryland			13b. COUNTY P. G.		13c. CITY OR TOWN Landover		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7318 Landover Road		
14. FATHER'S NAME FIRST MIDDLE LAST Richard T. Scrivner				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esther Crowley							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-30-0763		17. INFORMANT ADDRESS Upper Marlboro, MD. Mrs. Louise Stewart/Sister/9160 D'Arcy Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GUNSHOT WOUNDS OF CHEST AND ABDOMEN (Hand gun) 9650 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 19 xx 2/17 19 79				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 xx 2/17 19 79				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) shot by assailant			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) at home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 7318 Landover, Landover P. G. Co, MD			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Virginia L. Dolan MD				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 2/22/79			
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street, Baltg. MD 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Feb. 27, 1979		23c. NAME OF CEMETERY OR CREMATORY Harmony Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Landover P. G. Maryland			
24. FUNERAL DIRECTOR Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C.						25a. DATE REC'D. BY REGISTRAR MAR 16 1979		25b. REGISTRAR'S SIGNATURE P. H. H. H.			

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TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [illegible]

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-04890

FOR  
1. STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST <b>Rita D. Ciccarella</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2/21/79</b>		2b. HOUR 1 PM M	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS <b>55</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash., D. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Clinton Community Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges MD.</b>		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Camp Springs</b>	
13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>6316 Maxwell Drive</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry A. Beckert</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Jackson</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>577-30-4368</b>		17. INFORMANT ADDRESS <b>1063 Cedar Ridge Ct., Annapolis, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolism</b> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASH D. MI</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>9-17-</b> 19 <b>73</b> to <b>2-21</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>2-21-</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE 		DEGREE		22c. DATE SIGNED <b>2-21-79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Manoutchehr Moasser</b>		22e. ADDRESS <b>Rt. 301 &amp; Central Ave., Waldorf, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2-24-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, P.G., Maryland</b>						
24. FUNERAL DIRECTOR NAME <b>Robt E Wilhelm</b>		ADDRESS <b>4308 Suitland Rd., Suitland, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 27 1979</b>		
25b. REGISTRAR'S SIGNATURE 						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1st 12/10/10 2nd



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20% COTTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-04891	
1. DECEASED NAME (TYPE OR PRINT) <b>JULIA Antionette COLLISON</b>					2a. DATE OF DEATH MONTH <b>FEB.</b> DAY <b>27</b> YEAR <b>1979</b>		2b. HOUR <b>9:55 AM</b>				
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH <b>June</b> DAY <b>13</b> YEAR <b>1888</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.		7 UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		7 UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George</b> MD.					
10 CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CHEVY CHASE Nsg + Conv. CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md.</b>		13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>Bryantown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>G.D.</b>			
14 FATHER'S NAME FIRST <b>Samuel</b> MIDDLE <b></b> LAST <b>Collison</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Elizabeth</b> MIDDLE <b></b> LAST <b>Cecil</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>219-56-1327</b>		17. INFORMANT <b>Evelyn Clake Corso Wheaton</b>		ADDRESS <b>2809 Radius Rd. Md. 20902</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> <b>4340</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>ARTERIOSCLEROSIS GENERAL</b> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 MONTHS</b> <b>8 YRS.</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b></b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>DEC.</b> 19 <b>70</b> , to <b>FEB.</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>FEB. 23</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Leo M. Curtis M.D.</b> DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED <b>2-27-79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LEO M. CURTIS, M.D.</b>								22e. ADDRESS <b>8218 WISCONSIN AVE, BETHESDA, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>3/3/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Funeral Johns</b>		23d. LOCATION CITY OR TOWN <b>Hollywood St.</b> COUNTY <b>Mary's</b> STATE <b>Md.</b>			
24. FUNERAL DIRECTOR NAME <b>W. Clarke Mattingley</b> ADDRESS <b>Leonardtwn, Md.</b>								25a. DATE REC'D. BY REGISTRAR <b>MAR 5 1979</b>		25b. REGISTRAR'S SIGNATURE <b>W. Clarke Mattingley</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-04892	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Marguerite C. COMBS</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>February 20, 1979</b>			2b. HOUR <b>11:50a.m.</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 18, 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b>		IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		IF UNDER 24 HRS. HOURS MIN. <b>MIN.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince-Georges</b> MD.					
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sacred Heart Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN <b>Md. Ann Arundel Mayo</b>						13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS <b>301 Cadle Avenue</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Boone</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Johanna Delaney</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214-82-7572</b>		17. INFORMANT ADDRESS <b>Jos. F. Combs, 301 Cadle Ave, Mayo</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CONGESTIVE HEART FAILURE</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Adenocarcinoma of both Breasts 1946</b> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>3 years</b> <b>3 years</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 25</b> , 19 <b>78</b> , to <b>FEB 20</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>FEB 17</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.											
22b. SIGNATURE <b>Thomas F. Collins</b>				DEGREE <b>MD</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2-20-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>THOMAS F. COLLINS MD</b>				22e. ADDRESS <b>2600 QUEEN CHAPEL ROAD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb-23-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Washington</b>		COUNTY <b>Virginia</b>		STATE <b>Virginia</b>	
24. FUNERAL DIRECTOR NAME <b>Takoma Funeral Home</b>				ADDRESS <b>2540 New Rd NW DC</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 27 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Notary Public</b>	



52810-25

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-04893
1. FOR STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT)		FIRST CLYDE	MIDDLE JENNINGS	LAST CONNOR	2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 11, 1979		2b. HOUR 8:55a M	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7-21-1902		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.				
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors Hospital of P. G. County				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Warehouse		12b. KIND OF BUSINESS OR INDUSTRY House Clerk		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS 8500 - New Hampshire Ave.		
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Silver Spring						
14. FATHER'S NAME FIRST MIDDLE LAST William P. Connor				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Orndorff						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS same as above						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Miles Latent Carcinoma</u> <u>1629</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Lung Cancer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>70</u> , to <u>Feb. 11</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>Feb. 11</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Rafael C Lee</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2-11-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>RAFAEL C. LEE</u>				22e. ADDRESS <u>Clinton Md 20731</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-14-79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Pr. Geo. Md.				
24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc.				ADDRESS Mt. Rainier, Md.		25a. DATE REC'D. BY REGISTRAR FEB 13 1979		25b. REGISTRAR'S SIGNATURE <u>Putnam</u>		

MEDICAL CERTIFICATION

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13-04833

Items #18a-22a Film 0530 4/25/79 r STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-04894

1. DECEASED NAME (TYPE OR PRINT)			FIRST WILLIAM			MIDDLE B.			LAST COX			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2 21 19 79				2b. HOUR M 9:45 P M			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Aug. 19-1944 34 YRS.		6. AGE (IN YEARS) LAST BIRTHDAY 34		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2 22 19 79				2d. HOUR M 9:45 P M			
7a. BIRTHPLACE (CITY AND COUNTY) Alexandria Va.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.							
10. CITY OR TOWN OF DEATH Hyattsville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 630 Sheridan St.				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Florist.				12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Maryland				13b. COUNTY Prince George's				13c. CITY OR TOWN Hyattsville				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 630-Sheridan St.			
14. FATHER'S NAME FIRST MIDDLE LAST William C. Cox				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Pauldin				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 213-44-7107				16c. INFORMANT Jenna Tyler Cox 224 Brandyville Dr. P.D.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Disinfectant (pine oil) intoxication</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last.																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 2/21/ 19 79				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Absorption of disinfectant from enema											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 630 Sheridan St. Hyattsville Pr. Geo. Co. Md.											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER																DATE SIGNED 2-23-79			
ACTUAL SIGNATURE <i>[Signature]</i>				EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. ADDRESS 111 Penn St.															
23a. BURIAL, CREMATION, REMOVAL				23b. DATE Feb. 26-1979				23c. NAME OF CEMETERY OR CREMATORY St. Luke's				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.							
24. FUNERAL DIRECTOR NAME Arthur Walters				24b. ADDRESS 254 Carroll St. N.Y.C.				25. DATE REC'D. BY REGISTRAR FEB 27 1979				26. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

48870-07

UNITED STATES DEPARTMENT OF AGRICULTURE

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Department of Agriculture" and "United States" are faintly visible.]*

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, P. 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 2 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 79-04895					
1- STATE REGISTRAR						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR						2b. HOUR			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST						ELMER CROSS						2c. DATE PRONOUNCED DEAD MONTH DAY YEAR		2d. HOUR	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR		2d. HOUR	
male		negro		11/6/42		36						2 15 19 79		8:50 p m	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
Wash., D.C.				USA								Prince George's County MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly				Prince George's General Hosp.				Water proofing							
13a. STATE						13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Maryland						Seat Pleasant		MD				6801 Greig Street			
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Robert Cross						Grace Stewart									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
no				unknown				Robert Cross-father-4953 East Cap.				Street			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>966- Stab wound of chest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				8 P.M. 2-15- 79				Stabbed during altercation.							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
				home				6801 Greig St. Seat Pleasant Prince George's County MD							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED							
				Assistant				2-16-79							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
Ann M. Dixon, M.D.				111 Penn St.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial				2/21/79		Shiloh Baptist Church Cemetery				Ashland, Va.					
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Stewart Funeral Home-4001 Benning Road, NE						FEB 26 1979									

19-04882





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04896

1. FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>ANGELINA NMI D'AGOSTINO</b>			2a. DATE OF DEATH MONTH <b>02</b> DAY <b>22</b> YEAR <b>79</b>			2b. HOUR <b>3:45A.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH <b>07</b> DAY <b>26</b> YEAR <b>91</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS		7. IF UNDER 1 YEAR MONTHS <b>00</b> DAYS <b>00</b> HOURS <b>00</b> MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD.			
10. CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTHERN MARYLAND HOSPITAL CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>				13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Mitchville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>(Unknown)</b> MIDDLE <b></b> LAST <b>Bellella</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Marie</b> MIDDLE <b></b> LAST <b>(unknown)</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			
17a. SOCIAL SECURITY NO. <b>137-07-6288</b>				17. INFORMANT <b>Jennie Banda</b>		17b. ADDRESS <b>1028 Gifford Court Union, New Jersey</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary xsp failure</b> 2500 DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Debris Maltus + CCF</b> DUE TO, OR AS A CONSEQUENCE OF: (c) <b></b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>JULY 1, 1973</b> to <b>FEBRUARY 21, 1979</b> , that (I) (we) last saw the deceased alive on <b>FEBRUARY 21, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Dr. J. J. [Signature]</b>					DEGREE		22c. DATE SIGNED <b>FEB 22, 79</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Mondan [Signature]</b>
22e. ADDRESS <b>Clinton, Maryland</b>					22f. DATE SIGNED <b>FEB 22, 79</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Feb 26, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Sepulchre Cem.</b>		23d. LOCATION CITY OR TOWN <b>East Orange, New Jersey</b> COUNTY STATE		
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi Funeral Home, Inc.</b> ADDRESS <b>11800 New Hampshire Ave., Silver Spring, Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>FEB 26 1979</b>				
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					25c. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-04828

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP \_\_\_\_\_  
DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 79-04897									
2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR							
Feb 15 1979				1:30 P.M.							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
Female		White		12-25-02		76 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Pennsylvania		USA				Prince George's MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Clinton, Md.		Clinton Community Hosp.				Housewife					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
D. C.				Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2806 Erie Street, S.E.			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Robert T. Pace				Mary Mann							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
Yes				W. W. I		Mary V. Howard, Sister, Same as Above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4659 After Respiratory Infection DUE TO OR AS A CONSEQUENCE OF (b) Adverse A&H ID DUE TO OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		STATE					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET							
22a. I certify that (I) (this hospital) attended the deceased from Feb. 13, 1979, to Feb. 15, 1979, that (I) (we) last saw the deceased alive on Feb. 15, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
Dr. Manoutchehr Moasser								2-15-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Manoutchehr Moasser				Rt. 301 & Central Av., Waldorf, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE			
Burial		2-20-79		Arlington Natl. Cem		Arlington, Virginia					
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Robt E Wilhelm		FEB 22 1979		Rintyke Co. Pres.							
Funeral Home		Rd., Suitland, Md.									

MEDICAL CERTIFICATION

10810-01

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

(14)

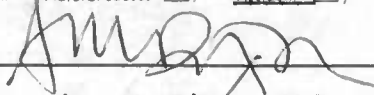
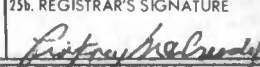
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 79-04898	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALBERT JOSEPH DELFIELD						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 1 10 1979		2b. HOUR M			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR MARCH 9, 1921		6. AGE (IN YEARS) LAST BIRTHDAY 57 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 11 1979	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WISCONSIN				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's Co. MD.	
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's Gen. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ACCOUNTANT		12b. KIND OF BUSINESS OR INDUSTRY DEPT OF AGRICULTURE	
13a. STATE MARYLAND						13b. COUNTY PRINCE GEORGES		13c. CITY OR TOWN GREENBELT		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST FRANK J. DELFIELD						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE MacDONALD					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT FRIEND				ADDRESS GREENBELT, MD. MAE L. CROSS, 8585 GREENBELT ROAD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute subdural hemorrhage</u> 888x Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Cirrhosis of liver											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. ? 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2) Apparently fell and struck head.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) ?		21f. LOCATION STREET CITY OR TOWN COUNTY STATE ? ? ? ?					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 						TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 1-12-79	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.						ADDRESS 111 Penn St.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 1/16/79		23c. NAME OF CEMETERY OR CREMATORY CHELTENHAM VETERANS CEM.				23d. LOCATION CITY OR TOWN COUNTY STATE CHELTENHAM MARYLAND	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS						25a. DATE REC'D. BY REGISTRAR JAN 16 1979		25b. REGISTRAR'S SIGNATURE 			
25c. ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901											

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15/05/01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 42 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. <b>79-04899</b>				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EVELYN E. DENNISON</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>02 12-79</b>			2b. HOUR <b>2:30AM</b>	
3. SEX <b>FEMAL</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JAN. 5, 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S</b> MD.			
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ECF PRINCE GEORGE GENERAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TRUST DEPT.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>NATL. BANK D.C.</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>PRINCE GEO.</b>		13c. CITY OR TOWN <b>MT. RAINIER</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3123 QUEENS CHAPEL ROAD</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES - TATOR</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>RUTH W. RIDGEWAY</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>-</b>		17. INFORMANT ADDRESS <b>EILEEN KEADY-ADDRESS SAME AS #13 ABOVE.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>1539 Metastatic Ca of Colon</b> IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Recurrent Thrombophlebitis</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>2-11-79</b> to <b>2-12-79</b> , that (I) (we) lost saw the deceased alive on <b>2-12-79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>H. A. Molavi, M.D.</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>H. A. MOLAVI, M.D.</b>					22e. ADDRESS <b>6005 Landover Rd Cheverly Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>FEB. 13, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL MEMORIAL PK.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>FALLS CHURCH-FAIRFAX- VA.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>CHAMBERS FUNERAL HOME - RIVERDALE, MARYLAND</b>					25a. DATE REC'D. BY REGISTRAR <b>FEB 16 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Eileen Keady</i>		

MEDICAL CERTIFICATION



70-04882

EXHIBIT 100  
CONTINUED

NO.	DATE	DESCRIPTION	AMOUNT	INITIALS
1	12-20-50	PAID TO [illegible]	100.00	[illegible]
2	12-20-50	PAID TO [illegible]	100.00	[illegible]
3	12-20-50	PAID TO [illegible]	100.00	[illegible]
4	12-20-50	PAID TO [illegible]	100.00	[illegible]
5	12-20-50	PAID TO [illegible]	100.00	[illegible]
6	12-20-50	PAID TO [illegible]	100.00	[illegible]
7	12-20-50	PAID TO [illegible]	100.00	[illegible]
8	12-20-50	PAID TO [illegible]	100.00	[illegible]
9	12-20-50	PAID TO [illegible]	100.00	[illegible]
10	12-20-50	PAID TO [illegible]	100.00	[illegible]

[Faint, illegible handwritten notes and signatures]

RECEIVED  
JAN 11 1951  
U.S. DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item #1a per phone call/Fun. Home State of Maryland									
1. FOR STATE REGISTRAR 2/6/79 rc DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
REG. NO. 79-04900									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>SARITA DURAN DE RONDEROS</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>2-6-79</b>		2b. HOUR <b>6:30 A</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5-14-1900</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>78</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) <b>Columbia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Columbia</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges Cty MD.</b>			
10. CITY OR TOWN OF DEATH <b>LAUREL</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GREAT LAUREL/BELTSVILLE HOSP.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Columbia</b>		13b. COUNTY		13c. CITY OR TOWN <b>BOGOTA</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Calle 102 #102</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Pablo Duran</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eloisa Rodriguez</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Cecilia de la Torre 10600 Norton Rd. Potomac Md.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>431-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>BRAIN HEMORRHAGE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>HYPERTENSION-</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>DIABETES</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 27</b> , 19 <b>79</b> , to <b>FEB 6</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>FEB 6</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Saltafuer</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2-6-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B.A. DELATORRE, MD</b>				22e. ADDRESS <b>320 MONTGOMERY ST - LAUREL, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/8/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Jardines de Immaculata</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bogota Columbia</b>			
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY FUNERAL HOMES, P.A. BETHESDA MARYLAND</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 6 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Richard...</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-04901			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Claude T. Dickinson, Sr.								2		2	79	1:50am	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Male		Caucasian		MONTH DAY YEAR Dec 6 1902		76 YRS.		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Virginia		USA				Prince George						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Clinton		Southern Maryland Hospital		Stone Mason		Construction							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		Pr Geo		Parkland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2908 Parkland Drive					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST James Q Dickinson		FIRST MIDDLE LAST Marion Taylor											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		100 12 7789		Dorothea K. Dickinson (wife)		Same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <u>COLD RESPIRATORY FAILURE</u> 496- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>ASHD Chronic URINARY TRACT INFECTION</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (the hospital) attended the deceased from <u>11-17</u> , 19 <u>70</u> , to <u>2-2</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>2-1</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		22b. SIGNATURE <u>William Kent Furst MD</u> DEGREE		22c. DATE SIGNED <u>2-2-79</u>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
William K. Furst, M.D.		9401 Indian Head Highway											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		5Feb1979		Washington National		Suitland PG Md							
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Robert E. Wilhelm Suitland, Md.		FEB 8 1979		<u>Robert E. Wilhelm</u>									

BP

10010-05

Dr. Rodriguez was notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04902

1. DECEASED NAME (TYPE OR PRINT) ROBERT H DIGGS			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 14, 1979			2b. HOUR 7:45PM			
3. SEX MALE		4. RACE NEGRO		5. DATE OF BIRTH MONTH DAY YEAR JULY 7 1900		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.			
10. CITY OR TOWN OF DEATH LANHAM		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTOR'S HOSPITAL OF P.G.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MARYLAND		13b. COUNTY P.G.		13c. CITY OR TOWN MITCHELLVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10209 ANNAPOLIS RD.	
14. FATHER'S NAME FIRST MIDDLE LAST Francis Gordon				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN SAA					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-05-8904		17. INFORMANT Robert G. Diggs - SAA					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia right upper lobe 496- DUE TO, OR AS A CONSEQUENCE OF (b) Chronic obstructive pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Metabolic Acidosis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2-14-1979 19 to 2-14-1979 19, that (I) (we) last saw the deceased alive on 2-14-1979 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
27b. SIGNATURE CHIN-CHUAN Hsu				DEGREE MD				27c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHIN-CHUAN Hsu				27e. ADDRESS 6905 Baltimore Blvd College park md 20740					
23a. BURIAL, CREMATION, REMOVAL (SPECIAL) Burial		23b. DATE 2/19/1979		23c. NAME OF CEMETERY OR CREMATORY St. Marys Ch. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Croom P.G. Md.			
24. FUNERAL DIRECTOR NAME Adams Funeral Home				ADDRESS Ciguasco, Md.		25a. DATE REC'D. BY REGISTRAR MAR 2 1979		25b. REGISTRAR'S SIGNATURE Rita J. Brady	

MEDICAL CERTIFICATION

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-04903

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>William Draughan</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>2</b> YEAR <b>1979</b>			2b. HOUR <b>7:30</b> <b>A</b>			
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>DEC.</b> DAY <b>11</b> YEAR <b>1930</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>48</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN. <b>0</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S</b> MD.			
10 CITY OR TOWN OF DEATH <b>CHESWYER</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGE'S GENERAL HOSP.</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SERVICE MGR.</b>		12b KIND OF BUSINESS OR INDUSTRY <b>ALUMINUM CO.</b>	
13a STATE <b>MARYLAND</b>		13b COUNTY <b>PRINCE GEO.</b>		13c CITY OR TOWN <b>HYATTSVILLE</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>4000 74th. AVENUE</b>	
14 FATHER'S NAME FIRST <b>ALVAH</b> MIDDLE <b>L.</b> LAST <b>DRAUGHAN</b>				15. MOTHER'S MAIDEN NAME FIRST <b>LULU</b> MIDDLE <b>--</b> LAST <b>COX</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>KOREAN</b>		17. INFORMANT <b>FRANCES DRAUGHAN-ADDRESS SAME AS #13 ABOVE</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Squamous Cell Cancer of the Lung</b> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 mos.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Bleeding duodenal ulcer</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>2-2</b> 19 <b>79</b> <b>May</b> to <b>2-3</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>2-2</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Cai-Yiu Yeung, MD</b> DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2-3-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Cai-Yiu Yeung, MD</b>						22e. ADDRESS <b>6525 Belcrest Rd #460 Hyattsville MD 20782</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>FEB. 6, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BRENTWOOD - P. G. - MD.</b>		
24. FUNERAL DIRECTOR NAME <b>CHAMBERS FUNERAL HOME-RIVERDALE, MARYLAND</b>			ADDRESS			25a. DATE REC'D. BY REGISTRAR <b>FEB 8, 1979</b>		25b. REGISTRAR'S SIGNATURE	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

100-2-203

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04904

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST SWEPSON A EAST			MONTH DAY YEAR 02 22 79			1:15PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Male	White	MONTH DAY YEAR Jan. 5, 1885	94 YRS.			IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
Norfolk, Virginia			USA			9. BALTIMORE CITY OR COUNTY OF DEATH		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
CHEVERLY			PRINCE GEO. EXTENDED CARE FACILITY			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE			13b. CITY OR TOWN			13c. STREET ADDRESS		
Maryland			St Mary's			Helen Est Mechanicsville, Maryland		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES?		
FIRST MIDDLE LAST John W. East			FIRST MIDDLE LAST Emme Hargove			16a. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES)		
16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		
No			577167499			Woodridge Drive Helen Estates Swepton A. East Jr. Mechanicsville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			19. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Abnormal heart disease (c) DUE TO, OR AS A CONSEQUENCE OF			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY		
Severe Myocardial infarction Left Coronary						HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
			WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21f. LOCATION		
						STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 1-2, 1979, to 2-22, 1979, that (I) (we) lost saw the deceased alive on 2-17, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE			22c. DATE SIGNED		
			T. SURY			MD		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			22f. DATE REC'D. BY REGISTRAR		
			6490 handover Rd, Landover, Md 20880			FEB 28 1979		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR OTHER PLACES		
Burial			2/26/1979			Charles Memorial Gardens		
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
NAME ADDRESS W. Clarke Mattingley Leonardtown, Maryland			FEB 28 1979			W. Clarke Mattingley		

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NEW YORK, N.Y.

Woodbridge Drive  
Mechanicville, Maryland

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-04905	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR	
		WILLIAM ANDREW EDELIN				FEBRUARY 14 1979				10:30 A <sub>M</sub>	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		Negro		MONTH 2 DAY 9 YEAR 1887		92 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Wash., D. C.		U. S. A.				Prince George's MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Lanham		Doctors' Hospital of Pr. Geo. Co.				Retired					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			
Maryland				P. G.		Lanham		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME				15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS					
Richard				Edelin		Maggie				Dorsey	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17 INFORMANT				ADDRESS	
No				217 28-7980		Mrs. Margaret Lee, 4312 Kinmount Rd., Md.				Lanham,	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA & CONG. HEART FAILURE										10 days	
4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) SENILITY & ARTERIO SCLEROSIS										10 yrs	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) RENAL INSUFFICIENCY											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
				P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2-14-79, to 2-14-79, that (I) (we) lost saw the deceased alive on 2-14-79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
Amos C. Lara				MD				2-15-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
ANDRES C. LARA				932 LANSAN ROAD MD LANHAM							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		STATE	
BURIAL				2-17-79		Mt. Olivet Cemetery		Washington,		D. C.	
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John T. Rhines Co.-3030-12th-Street, N.E., D.C.						EB 22 1979		Lantry McCurdy			

13-04202

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

Some of the specimens  
collected at Camp Hager, Alaska, 1919

1919-1920

1919-1920

1919-1920



## MEDICAL EXAMINER NOTIFIED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the medical examiner be notified of a death occurring within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 7/77  
(VRA 15 (4))

Add'l Info. Film G529 3/13/79 kag

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04906

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR		P	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		02		09		79	
CHARLES T. EDMONDSON												11:15 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		MONTH DAY YEAR Oct 2, 1905 1906		73 72 YRS.		MONTHS		DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Pennsylvania		USA				PRINCE GEORGE'S COUNTY MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Cheverly		Prince George's Gen'l Hospital		Dir of Audit		US Treasury							
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS							
Maryland		Pr. Geo's Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3450 Toledo Terrace Apt 519							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST Thomas J. Edmondson		FIRST MIDDLE LAST Mary E. Fettingner											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
NO		579-58-4804		Edmondson		Martha Edmondson (wife) same as above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4379 MASSIVE INTRAVENTRICULAR HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE CEREBROVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)		PREVIOUS CVA.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) this hospital attended the deceased from 2/9 19 79 to 2/9 19 79, tho (1) (we) last saw the deceased alive on 2/9 19 79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death.		22b. SIGNATURE William R. Leahy MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2/10/79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
William R. Leahy MD		6201 GREENBELT RD - COLLEGE PARK.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		Feb 12, 1979		Fort Lincoln Cemetery		Brentwood Pr. Geo's Md.							
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Francis Gasch's Sons, PA Hyattsville, Md.		FEB 14 1979		William R. Leahy									





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 79-04907	
1. DECEASED NAME (TYPE OR PRINT) <b>Helen R. Elliott</b>						2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>2-20 1979</b>		2b. HOUR M <b>11</b> AM			
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>3-31-08</b>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>78</b>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>2-20 1979</b>		7d. HOUR M <b>11</b> AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mass</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD.					
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dr. George Gen. Hosp., (DCA)</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a. STATE <b>Md.</b>		13b. COUNTY <b>Pr. Geo.</b>		13c. CITY OR TOWN <b>Bowie</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>12119 Tawny Lane</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John A. O'Brien</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Joanna Honohan</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>n/a</b>		17. INFORMANT <b>Thomas Elliott</b>		ADDRESS <b>Same as #13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>		TITLE (SPECIFY) <b>Deputy</b>		MEDICAL EXAMINER				DATE SIGNED <b>2-20-79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez</b>		ADDRESS <b>12804 Willowland Circle, Jantell, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>24 FEB 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lindenwood Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Stoneham, Middlesex, Mass</b>			
24. FUNERAL DIRECTOR NAME <b>Robert G. Beall Funeral Home</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 26 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCready</b>					
ADDRESS <b>1212 West St. Annapolis, Md. 21401</b>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04908

1. DECEASED NAME (TYPE OR PRINT) JAMES THOMAS ESTENES			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 10 1979		2b. HOUR 4:50 A.M.
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 18 1911	6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.		
10. CITY OR TOWN OF DEATH ANDREWS AFB FORCE BASE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MALCOLM GROW USAF MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AIRCRAFT MECHANIC	12b. KIND OF BUSINESS OR INDUSTRY MILITARY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE NEW YORK		13b. COUNTY ONEIDA	13c. CITY OR TOWN TABERG	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS RURAL DELIVERY 1
14. FATHER'S NAME (DECEASED) FIRST MIDDLE LAST MICHAEL ESTENES		15. MOTHER'S MAIDEN NAME (DECEASED) FIRST MIDDLE LAST ELIZABETH ROTHAUSEN		ADDRESS SAME AS 13	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1933, 1946-63 074010327		17. INFORMANT GLADY M (WIFE)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>lung carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1629					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min 8 hr Dx - 3 wks.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>James M. Row</u> MD.		DEGREE MD.		22c. DATE SIGNED 10 Feb 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James M. Row		22e. ADDRESS Andrews AFB			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Feb. 13, 1979	23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia
24. FUNERAL DIRECTOR NAME MURPHY FUNERAL HOMES, INC.		4510 Wilson Blvd. Arlington, Va. 22203		25a. DATE REC'D. BY REGISTRAR FEB 15 1979	25b. REGISTRAR'S SIGNATURE <u>Patricia McCready</u>

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DEPARTMENT OF JUSTICE

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-04909	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NORMAN J FOOTE						2a. DATE OF DEATH MONTH DAY YEAR 02-22-79			2b. HOUR 11:15 P		
3. SEX M		4. RACE Col. American		5. DATE OF BIRTH MONTH DAY YEAR 7 20 1916		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.					
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEO. GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. CITY OR TOWN P.G. 13c. CITY OR TOWN Bowie						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS NONE			
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Henson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-18-2649		17. INFORMANT ADDRESS Marie Centee-4009-91st Ave. Landover, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MASSIVE DIAPHRAMATIC M.I. 410- } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which } (b) CHF gave rise to immediate } cause (a), stating the } underlying cause last } (c) SEVERE ARTERIALCLERATIC HEART DISEASE										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE H. A. Wise Jr. M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-23-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HENRY A. WISE JR. M.D.						22e. ADDRESS 8901 GEORGE PALMER HIGHWAY, LANHAM MD. 20801					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/28/79		23c. NAME OF CEMETERY OR CREMATORY St Johns		23d. LOCATION CITY OR TOWN COUNTY STATE Odenton AA Md.					
24. FUNERAL DIRECTOR NAME William Reese Sons MONT-ANNA, Md.						25a. DATE REC'D. BY REGISTRAR FEB 26 1979		25b. REGISTRAR'S SIGNATURE Ricky McBrady			

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PRINTED BY THE GOVERNMENT PRINTER, CALCUTTA.

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ACUTE MASSIVE SUBARACHNOID HEMORRHAGE

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 79-04910																			
1. DECEASED NAME (TYPE OR PRINT) <b>Viola R. FORT</b>										2a. DATE KNOWN OF DEATH ESTI-MATED <b>2-15-79</b>										2b. HOUR <b>12 PM</b>																													
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>6-14-09</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>2-15-79</b>										2d. HOUR <b>12 PM</b>																											
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington DC</b>										7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES MD</b>																			
10. CITY OR TOWN OF DEATH <b>Chesley</b>										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince Georges General Hospital</b>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>										12b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>																			
13a. STATE <b>Maryland</b>										13b. COUNTY <b>Prince Georges</b>										13c. CITY OR TOWN <b>Landonov</b>										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS <b>9200 East Ridge Drive</b>									
14. FATHER'S NAME (TYPE OR PRINT) <b>William Franklin ROCK</b>										15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) <b>Anna Viola GIBSON</b>										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>										16b. SOCIAL SECURITY NO. <b>216-64-0984</b>										17. INFORMANT <b>John T. Fort, 3404 Village Dr., N., Md.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary atherosclerotic cerebro-vascular accident</b>										PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary atherosclerotic cerebro-vascular accident</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
436- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										436- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Chronic Obstructive pulmonary disease; Left femoral subcapital fracture</b>										PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Chronic Obstructive pulmonary disease; Left femoral subcapital fracture</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR: A.M. MONTH DAY YEAR P.M. <b>7-29 1978</b>										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Fell at home bedroom floor, unsteady gait</b>																													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>										21f. LOCATION STREET CITY OR TOWN COUNTY STATE																													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																													
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>										TITLE (SPECIFY) <b>DEPUTY</b>										DATE SIGNED <b>2-15-79</b>																													
EXAMINER'S NAME (TYPE OR PRINT) <b>AUGUSTO P. RODRIGUEZ M. D.</b>										ADDRESS <b>TANTALLON, MARYLAND 20022</b>										MEDICAL EXAMINER <b>WILLOW WIND CIRCLE</b>																													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>										23b. DATE <b>Feb. 19, 1979</b>										23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>										23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood, Maryland</b>																			
24. FUNERAL DIRECTOR <b>Robert G. Beall Funeral Home</b>										24. FUNERAL DIRECTOR <b>Robert G. Beall Funeral Home</b>										25a. DATE REC'D. BY REGISTRAR <b>FEB 26 1979</b>										25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>																			
24. FUNERAL DIRECTOR <b>Robert G. Beall Funeral Home</b>										24. FUNERAL DIRECTOR <b>Robert G. Beall Funeral Home</b>										25a. DATE REC'D. BY REGISTRAR <b>FEB 26 1979</b>										25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>																			

10-04810

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

FRANCE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-04911		
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NICK (NMN) FOTOS						2a. DATE OF DEATH MONTH DAY YEAR 02-24-79		2b. HOUR 4:45AM		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 15, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.						
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Furrier		12b. KIND OF BUSINESS OR INDUSTRY Am. Fur.Co.				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Montgomery Sil.Sprg.											13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 13103 Fernedge Rd.
14. FATHER'S NAME FIRST MIDDLE LAST Stavrou Fotos				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christine Mezitis								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   IF YES, GIVE WAR OR DATES No. --				16b. SOCIAL SECURITY NO. 121-07-0824		17. INFORMANT ADDRESS Effie G.Fotos 13103 Fernedge Rd.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Cardiac Arrhythmia 492- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Emphysema										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (s) (this hospital) attended the deceased from 2/8, 19 79, to 2/24, 19 79, that (1) we last saw the deceased alive on 2/24, 19 79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, circle X.)												
22b. SIGNATURE Louis Steinberg						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Louis Steinberg						22e. ADDRESS 6490 Landover Rd, Landover Md						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2/28/79		23c. NAME OF CEMETERY OR CREMATORY Gate Of Heaven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Montg. Md.				
24. FUNERAL DIRECTOR NAME W.W. CHAMBERS CO.						ADDRESS SILVER SPRING MARYLAND		25a. DATE REC'D. BY REGISTRAR MAR 2 1979		25b. REGISTRAR'S SIGNATURE H. J. McCreedy		

10-04811

SECTION OFFICE AND UNIT

NAME	CHARACTER	DATE	TIME	LOCATION
CHERRY	PRINCE GEORGE GENERAL HOSPITAL	10-04-52	11:00	PRINCE GEORGE
STAVROU	PRINCE GEORGE GENERAL HOSPITAL	10-04-52	11:00	PRINCE GEORGE
STAVROU	PRINCE GEORGE GENERAL HOSPITAL	10-04-52	11:00	PRINCE GEORGE
STAVROU	PRINCE GEORGE GENERAL HOSPITAL	10-04-52	11:00	PRINCE GEORGE
STAVROU	PRINCE GEORGE GENERAL HOSPITAL	10-04-52	11:00	PRINCE GEORGE
STAVROU	PRINCE GEORGE GENERAL HOSPITAL	10-04-52	11:00	PRINCE GEORGE
STAVROU	PRINCE GEORGE GENERAL HOSPITAL	10-04-52	11:00	PRINCE GEORGE
STAVROU	PRINCE GEORGE GENERAL HOSPITAL	10-04-52	11:00	PRINCE GEORGE
STAVROU	PRINCE GEORGE GENERAL HOSPITAL	10-04-52	11:00	PRINCE GEORGE
STAVROU	PRINCE GEORGE GENERAL HOSPITAL	10-04-52	11:00	PRINCE GEORGE

10-04811

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DMMH - 17  
(VR A15 ME (5))  
15M 7/77

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-04912

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Morton Cecil		MIDDLE FRIEDMAN		LAST FRIEDMAN		2b. DATE KNOWN OF DEATH ESTI- MATED		MONTH 2/21		DAY 19		YEAR 79		2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 7-28-28		YEAR 50 YRS.		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD		2d. HOUR M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		NEW YORK		7b. CITIZEN OF WHAT COUNTRY?		U S A		8. MARRIED WIDOWED		<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH		Pr. George		MD.	
10. CITY OR TOWN OF DEATH		CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		PRINCE GEORGE'S GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		CARTOGRAPHER		12b. KIND OF BUSINESS OR INDUSTRY		U S GOV'T			
13a. STATE		MARYLAND		13b. COUNTY		PR. GEORGE'S		13c. CITY OR TOWN		OXON HILL		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		5613 DUNDALK DRIVE	
14. FATHER'S NAME FIRST WILLIAM		MIDDLE		LAST FRIEDMAN		15. MOTHER'S MAIDEN NAME FIRST LILLIAN		MIDDLE		LAST COHEN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO						577-36-0096		BERNICE MAY FRIEDMAN (SAME AS No. 13)									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		4292		Coronary atherosclerotic cardiovascular disease		DUE TO, OR AS A CONSEQUENCE OF						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.				(b)		DUE TO, OR AS A CONSEQUENCE OF											
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		Diabetic Mellitus, Obesity															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion									
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		Augusto P. Rodriguez		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER		DATE SIGNED		2/21/79							
EXAMINER'S NAME (TYPE OR PRINT)		Augusto P. Rodriguez		12800 Willow Wind Circle, Oxon Hill, Md. 20022		ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		BURIAL		23b. DATE		2/25/1979		23c. NAME OF CEMETERY OR CREMATORY		MOUNT LEBANON CEMETERY		23d. LOCATION CITY OR TOWN		PR. GEO.		STATE MARYLAND	
24. FUNERAL DIRECTOR NAME		M STEIN HEBREW MEMORIAL F.H.		25a. DATE REC'D. BY REGISTRAR		FEB 26 1979		25b. REGISTRAR'S SIGNATURE		[Signature]							
232 CARROLL STREET, N.W. WASH. D.C.																	

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RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE  
WASHINGTON, D.C. 20535

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TO : DIRECTOR, FBI (100-441100)  
FROM : SAC, NEW YORK (100-100000) (P)  
SUBJECT: [Illegible]

RE: [Illegible]  
[Illegible]

DATE: [Illegible]  
[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 79-04913				
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR
1. DECEASED NAME FIRST MIDDLE LAST CORENA CELESTE GAMBLE				FEBRUARY 15, 1979				3:14 PM
3 SEX FEMALE	4 RACE NEGROID	5. DATE OF BIRTH MONTH DAY YEAR JULY 17 1903		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GEORGIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.			
10. CITY OR TOWN OF DEATH ANDREWS AFB	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MALCOLM GROW USAF MEDICAL CENTER			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COOK		12b. KIND OF BUSINESS OR INDUSTRY RESTAURANT		
13a. STATE MARYLAND				13b. COUNTY PRINCE GEORGES UPPER MARLBORO		13c. CITY OR TOWN P.O. BOX 181		
14. FATHER'S NAME FIRST MIDDLE LAST OSCAR		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLA POLLARD (D)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 158-14-1091		17. INFORMANT ADDRESS ELLA EDWARDS (DAU) SAME AS ITEM #13c				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Renal &amp; Hepatic Failure, Sepsis and Coagulopathy</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Disseminated Intravascular Coagulation</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>25 Jan</i> , 19 <i>79</i> , to <i>15 Feb</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>15 Feb</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>William A. Pollan</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 15 Feb 79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM A. POLLAN, CAPT, USAF, MC				22e. ADDRESS MALCOLM GROW USAF MEDICAL CENTER ANDREWS AFB, MARYLAND 20331				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 2/17/79		23c. NAME OF CEMETERY OR CREMATORY Childs Funeral Home		23d. LOCATION CITY OR TOWN COUNTY STATE Red Bank, New Jersey		
24. FUNERAL DIRECTOR NAME ALEXANDER S. POPE 2617 Pennsylvania Ave., S.E.				25a. DATE REC'D. BY REGISTRAR FEB 22 1979		25b. REGISTRAR'S SIGNATURE <i>Henry McCreedy</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

79-04914

1. DECEASED-NAME (Type or print) First Middle Last <b>WALLACE J GAMBLE</b>			2a. DATE OF DEATH Month Day Year <b>2 4 79</b>			2b. HOUR <b>7:20AM</b>					
3. SEX <b>Male</b>		4. RACE <b>Blk</b>		5. DATE OF BIRTH <b>Dec. 10, 1925</b>		6. AGE (In years last birthday) <b>53</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>S. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>PRINCE GEORGE'S COUNTY</b> Md.					
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>PRINCE GEORGE'S GEN HOSP.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Construction Worker</b>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>PG</b>		13c. CITY OR TOWN <b>Landover</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>7900 Sheriff Rd.</b>			
14. FATHER'S NAME First Middle Last <b>Marion Gamble</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Dora Dickey</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. <b>Not Stated</b>		17. INFORMANT Address <b>Odessie Gamble (wife) 7900 Sheriff Rd.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF ESOPHAGUS</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>HEPATIC CIRRHOSIS; RENAL FAILURE</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>1-23</b> , 19 <b>79</b> , to <b>2-4</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>2-4</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Beaujeu Watkins</b>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2-4-79</b>				
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Feb. 10, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hopkins Cem</b>		23d. LOCATION (City or Town) (County) (State) <b>Lynchburg S. C.</b>					
24. FUNERAL DIRECTOR <b>Watson Funeral Home 3435 14th St., N. W.</b>					25a. RECEIVED BY REGISTRAR <b>FEB 9 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

10-04314

UNITED STATES DEPARTMENT OF JUSTICE

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PRINCE GEORGE'S COUNTY

PRINCE GEORGE'S COUNTY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-04915	
1. FOR STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES A. Alexander GARNER						2a. DATE OF DEATH MONTH DAY YEAR 02 16 79		2b. HOUR 1:50PM	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 11, 1889		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 1 YEAR HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.					
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tobacco Farmer		12b. KIND OF BUSINESS OR INDUSTRY Tenent			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md.		13c. COUNTY Anne Arundel		13d. CITY OR TOWN Lothian		13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13f. STREET ADDRESS 1205 Marlboro Road			
14. FATHER'S NAME FIRST MIDDLE LAST James Henry Garner				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura -- Farrell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Barbara Bauckman-Lothian, Md. 20820					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ① Cerebrovascular Accident 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ② Coronary Artery Disease (c) ③ Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from Jan. 23, 19 79, to Feb. 16, 19 79, that (I) (we) last saw the deceased alive on Feb. 16, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Hernandez		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2/16/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Tomas J. Hernandez, M.D.				22e. ADDRESS Prince Geo's General Hospital Cheverly, Maryland.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE 2/22/79		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington (Dist. of Col.)					
24. FUNERAL DIRECTOR Richard A. Coleman - Upper Marlboro, Maryland 20870				25a. DATE REC'D. BY REGISTRAR MAR 6 1979		25b. REGISTRAR'S SIGNATURE L. J. Kennedy					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		79-04916						REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) Mildred J. Gogos					2a. DATE OF DEATH MONTH DAY YEAR February 17, 1979			2b. HOUR 9:30am M		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jan 27 1902		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.				
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctor's Hospital of P.G. County				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stenographer		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.		
13a. STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Cabin John		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel T. Johnson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice MacArthur					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATFS) Unknown		17. INFORMANT ADDRESS Alice E Gogos, Dtr., Same as item 13.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PERIPHERAL VASCULAR COLLAPSE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>SYSTEMIC CIRCULATORY FAILURE</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST: <u>1125</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>30 hours</u> <u>3 days</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>MASSIVE GASTROINTESTINAL HEMORRHAGE, ACUTE RENAL FAILURE</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>1. Chronic Gastric Ulcer &amp; Obstruction</u> <u>2. Chronic Gastric Ulcer &amp; Hemorrhage</u> <u>3. Chronic Gastric Ulcer &amp; Perforation</u>				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>FEB. 14</u> , 19 <u>79</u> , to <u>FEB. 17</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>FEB 17</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>George S. Banning MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>2-17-79</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE S. BANNING				22e. ADDRESS 5806 BALTIMORE BLVD. Hyattsville, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/28/1979		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.				
24. FUNERAL DIRECTOR NAME JOSEPH GAWLER'S SONS INC. 5138 WISD. AVE., N. W. WASH., D. C. 20916				25a. DATE RECEIVED BY REGISTRAR MAR 1 1979		25b. REGISTRAR'S SIGNATURE <u>John H. Banning</u>				

MEDICAL CERTIFICATION

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-04917

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Kathryn C. GONZALES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 19, 1979</b>		2b. HOUR <b>10:04 AM</b>					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct 22, 1928</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>50</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George</b> MD.				
10. CITY OR TOWN OF DEATH <b>Lanham</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Doctors Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>analyst</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>US Govt</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE <b>Md</b>		13b. COUNTY <b>PG</b>		13c. CITY OR TOWN <b>Laurel</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>321 Talbott Avenue</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Walter Robison</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mildred Nelson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS <b>Richard L. Gonzales 8710 Hayshed Lane Columbia, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>hepatic Coma</b> <b>1629</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>metastatic disease of liver</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>small cell carcinoma of lung</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>18 months</b>		
								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from <b>2/18/79</b> to <b>2/20/79</b> , that (I) (we) last saw the deceased alive on <b>2/18/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (It would) (did not) view the body after death.										
22b. SIGNATURE <b>Robert Depetris</b> MD					DEGREE <b>MD</b>		22c. DATE SIGNED <b>2/20/79</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERTO DEPETRIS</b>					22e. ADDRESS <b>6776 RACE TRACK RD Bowie, Md 20715</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Feb. 24, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Laurel, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Donaldson Funeral Home, Laurel, Md</b> ADDRESS					25a. DATE REC'D BY REGISTRAR <b>MAR 5 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Kathryn McCreedy</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 79-04918			
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <i>Charles KYLE GOODMAN</i>										2a. DATE KNOWN OF DEATH		2b. HOUR	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>11-11-32</i>		6. AGE (IN YEARS) <i>46</i> YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD <i>2-27-79</i>		7d. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George</i> MD.							
10. CITY OR TOWN OF DEATH <i>Chesley</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prince Georges Hosp. (DOA)</i>						12a. USUAL OCCUPATION (TYPE OF WORK) <i>Marine Corps</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Marine Corps</i>					
13a. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <i>Maryland</i>		13b. COUNTY <i>Prince Georges</i>		13c. CITY OR TOWN <i>Upper Marlboro</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>12606 Cambleton Drive</i>							
14. FATHER'S NAME FIRST MIDDLE LAST <i>Alfred -- Goodman</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Sara -- Piel</i>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>							
16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS <i>Patricia K. Goodman-Dr., Upper Marlboro, Md. 20870</i>											
18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary atherosclerosis cardiovascular disease</i> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) <i>Deputy</i>				MEDICAL EXAMINER				DATE SIGNED <i>2-28-79</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez</i>				ADDRESS <i>12800 Annapolis Ave., Tan Towan</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>3/3/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Barnabas Cemetery</i>				23d. LOCATION (CITY OR TOWN) <i>Leeland (Pr. Geo's) Md.</i> COUNTY STATE					
24. FUNERAL DIRECTOR <i>Richard A. Coleman</i>						25a. DATE REC'D. BY REGISTRAR <i>MAR 6 1979</i>				25b. REGISTRAR'S SIGNATURE <i>R. J. Kelly</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 79-04919			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LOUISE C. GRAY</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>2 28 79</b>		2b. HOUR <b>8:00P M</b>	
3 SEX <b>F</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>August 24, 1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George</b>	
10 CITY OR TOWN OF DEATH <b>RIVERDALE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>EUGENE LELAND MEMORIAL HOSPITAL</b>		12a USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>housewife</b>		12b KIND OF BUSINESS OR INDUSTRY <b>home</b>	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Md</b> 13b COUNTY <b>Howard</b> 13c CITY OR TOWN <b>Jessup</b> 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e STREET ADDRESS <b>Benliss Trailer Park Lot 31</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>Garfield P. Curry</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret L. Keeney</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b SOCIAL SECURITY NO <b>213 12 1501</b>		17. INFORMANT ADDRESS <b>James N. Garber same as above</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant</b> <b>1830</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Intestinal Obstruction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Carcinomatosis of Ovary</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>2/10/79</b> , 19____, to <b>3/1/79</b> , 19____, that (I) (we) last saw the deceased alive on <b>2/28</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>W. L. Brown, MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/1/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>March 5, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dorsey, Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Donaldson D.H. Ford, MD</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 12 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Trifony McCreedy</b>	

10-01919

2 23 73 8:00P

GRAY

HOUSE

ELUCID LIVING EDITIONAL HOSPITAL

RIVERDALE

MADE IN U.S.A. 100% COTTON 100% COTTON 100% COTTON

MADE IN U.S.A.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP \_\_\_\_\_

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-04920	
1. FOR STATE REGISTRAR						2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LENA K. GREEN						2a. DATE OF DEATH		MONTH DAY YEAR 02-04-79		2b. HOUR 12:50 AM	
3. SEX female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 10-10-1894		6. AGE (IN YEARS LAST BIRTHDAY) 84		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.					
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GEN. HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Charles		13c. CITY OR TOWN Brandywine		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Kf. 1-Box 136			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph King				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Matilda Wade							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578-44-2622		17. INFORMANT ADDRESS 5537 Bass Pl. Washington, D.C.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis 6826 DUE TO, OR AS A CONSEQUENCE OF (b) cellulitis left leg DUE TO, OR AS A CONSEQUENCE OF (c) unknown										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) dehydration, old cerebrovascular accident											
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1/31, 1979, to 2/3, 1979, that (I) (we) last saw the deceased alive on 2/3, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE [Signature] DEGREE MD						22c. DATE SIGNED 2/4/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEVEN M POLLAK MD						22e. ADDRESS 4700 Arth Pl. CAMP SPRING					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/8/79		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivett Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Bladenburg Rd. Wash. D.C.					
24. FUNERAL DIRECTOR NAME Martell Adams						25a. DATE REC'D. BY REGISTRAR FEB 13 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

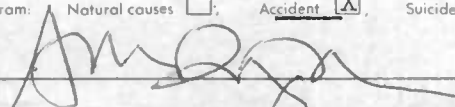
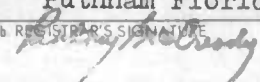
MEDICAL CERTIFICATION



10-01250

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 2 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 79-04921			
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SYLVESTER L. GILYARD						2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 2 22 1979		2b. HOUR M			
3. SEX male		4. RACE negro		5. DATE OF BIRTH MONTH DAY YEAR 6-28-1951		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 27		IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2 22 1979			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Florida				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.			
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor F.B.I.		12b. KIND OF BUSINESS OR INDUSTRY Govt.			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Temple Hills		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4710 23rd. Parkway					
14. FATHER'S NAME FIRST MIDDLE LAST Henry Gilyard				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Willie Mae Douglas									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 265-04-8620		17. INFORMANT ADDRESS Shirley Ann Gilyard Same as in Item 13a							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cranio-cerebral injuries</u> 8147 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6:30 PM 2-22-1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Pedestrian struck by vehicle.							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1300 blk. Owen Rd. Oxon Hill Prince George's MD							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 2-23-79	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2-27-1979		23c. NAME OF CEMETERY OR CREMATORY San Mateo Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE San Mateo Putnam Florida			
24. FUNERAL DIRECTOR NAME George P. Kalas 26160 Oxon Hill Rd. Oxon Hill Maryland						25a. DATE REC'D BY REGISTRAR FEB 27 1979		25b. REGISTRAR'S SIGNATURE 					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) <b>Filomena</b>			FIRST MIDDLE LAST <b>Giraldi</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Feb 14, 1979</b>			2b. HOUR <b>10:05A<sub>M</sub></b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan 22, 1890</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b> MD.				
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince George's Gen'l Hosp</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a. STATE <b>New Jersey</b>			13b. COUNTY <b>Passaic</b>		13c. CITY OR TOWN <b>Patterson</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>22 Ellison Street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alexander Andriate</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Josephine Onarato</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>146-24-2812</b>		17. INFORMANT ADDRESS <b>Robert Giraldi (son) Cheverly, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Vascular artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>5 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>Sept 8</u> , 19 <u>78</u> , to <u>Feb 14</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>Feb 13</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Leonard P. Appel</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>2/15/79</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LEONARD P. APPEL, MD</b>			22e. ADDRESS <b>3231 Superior Ln. Bowie, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Feb 19, 1979</b>		23c. NAME OF CEMETERY OR CREMATOR <b>Holy Sepulchre Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Totowa Brogh Passaic, N. J.</b>			
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons, PA Hyattsville, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 21 1979</b>				

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGE 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))  
15M 7/77

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 79-04923									
1. DECEASED NAME (TYPE OR PRINT) <b>Geraldine Deater Guinn</b>										2a. DATE KNOWN OF DEATH ESTIMATED <b>2-6 1979</b>										2b. HOUR <b>M</b>																			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>10-29-21</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b>		7. IF UNDER 1 YR. MONTHS <b>5</b> DAYS <b>1</b> HOURS <b>1</b> MIN.		8. DATE PRONOUNCED DEAD <b>2-6 1979</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b>		10. CITY OR TOWN OF DEATH <b>Hyattsville</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5711 43rd Ave to P.G. Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Waitress</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>																			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Port News, Va.</b>										7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>																			
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Maryland Prince Georges Hyattsville</b>										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS <b>5711 43rd Avenue</b>																			
14. FATHER'S NAME FIRST <b>Stephen</b> MIDDLE <b>Hurley</b> LAST <b>Duck</b>										15. MOTHER'S MAIDEN NAME FIRST <b>Ethel</b> MIDDLE <b>Guthrey</b> LAST <b>Hartless</b>										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES) <b>None</b>																			
16b. SOCIAL SECURITY NO. <b>579-22-5966</b>										17. INFORMANT <b>East Riverdale, Md. 20840</b>										17. INFORMANT <b>Thelma C. Chumbris-sister 5600 56th Ave</b>																			
18. CAUSE OF DEATH (Enter only one cause or the far, (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic obstructive coronary vascular disease</b> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>DUE TO, OR AS A CONSEQUENCE OF</b> (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion										22b. DATE <b>2/6/79</b>										22c. MEDICAL EXAMINER <b>August P. Rodriguez</b>																			
22d. EXAMINER'S NAME (TYPE OR PRINT) <b>August P. Rodriguez</b>										22e. ADDRESS <b>12800 W. Howard Ave, Suitland, Md.</b>										22f. DATE REC'D. BY REGISTRAR <b>FEB 9 1979</b>																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>										23b. DATE <b>2-9-79</b>										23c. NAME OF CEMETERY OR CREMATORY <b>Washington National Cen. Suitland, Md.</b>																			
24. FUNERAL DIRECTOR <b>J. William Lee's Sons Co.</b>										24b. DATE REC'D. BY REGISTRAR <b>FEB 9 1979</b>										24c. REGISTRAR'S SIGNATURE <b>Anthony M. Crady</b>																			

BP

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General John Quinn

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-04924	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>ESTHER M. HANSON</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>FEB. 12, 1979</b>			2b. HOUR <b>10:55p<sub>M</sub></b>		
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 11, 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Minnesota</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County MD</b>					
10. CITY OR TOWN OF DEATH <b>Lanham, Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Doctors' Hosp. of P. G. Co.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <b>Minn Hubbard Park Rapids</b>						13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET ADDRESS <b>P O Box 49</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Leuenick</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Sierslanska</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no n/a</b>				16b. SOCIAL SECURITY NO. <b>480 36 8545 A</b>		17. INFORMANT <b>4017 Welsley La Lawrence Daniels Bowie, Md. 20715</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <u>1-26</u> , 19 <u>79</u> , to <u>Feb 12</u> , 19 <u>79</u> , that (we) last saw the deceased alive on <u>Feb 12</u> , 19 <u>79</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.											
22b. SIGNATURE <u>Farheen Haider</u> M.D. DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED <b>14 Feb 79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Pathologist A. Haider M.D.</u>								22e. ADDRESS <b>Doctors Hospital of Prince Georges</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>17 FEB 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Park Rapids, Hubbard, Minn.</b>			
24. FUNERAL DIRECTOR NAME <b>Robert G. Beall Funeral Home</b>								25a. DATE REC'D. BY REGISTRAR <b>FEB 21 1979</b>			
24. FUNERAL DIRECTOR ADDRESS <b>1212 West St. Annapolis, Md. 21401</b>								25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

19-0484

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-04925

REG. NO.

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>SIDNEY HARRIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2 12 79</b>			2b. HOUR <b>9:50A</b> M				
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 25-1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S COUNTY</b> MD.				
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGE'S GEN HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retire-Disability</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Va</b>					13b. COUNTY <b>Louisa</b>		13c. CITY OR TOWN <b>Town</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charlie S. Harris</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jane Harris</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS <b>Oxen Hill, Maryland</b> <b>Son/ Sidney E. Richardson-1717-Feenwood Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>exhaustion</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>leukomyosarcoma of stomach</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>1519</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>January 19 78</b> to <b>Feb 12 79</b> , that (I) (we) lost saw the deceased alive on <b>Feb 11 19 78</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										
22b. SIGNATURE <b>[Signature]</b>					DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>2/12/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D. J. Haidne</b>					22e. ADDRESS <b>Hyattsville, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>2-16-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Louisa, Virginia</b>		
24. FUNERAL DIRECTOR NAME <b>Thomasson's Funeral Home</b>					ADDRESS <b>Louisa Va.</b>			25a. DATE REC'D. BY REGISTRAR <b>FEB 28 1979</b>		
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>										

24. FUNERAL DIRECTOR  
NAME  
**Latney's Funeral Home**

ADDRESS

25a. DATE REC'D. BY REGISTRAR  
**FEB 28 1979**

25b. REGISTRAR'S SIGNATURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 22 is checked, any injury, or other traumatic event, the medical examiner must be notified of cause.

MEDICAL EXAMINER NOTIFIED RELEASED FOR DOCTORS SIGNATURE

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-04926	
1. FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN NOLAN HARWELL						2a. DATE OF DEATH MONTH DAY YEAR FEB 8 1979			2b. HOUR 4:22 P <sub>M</sub>		
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR AUGUST 13 1913		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GEORGIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.					
10 CITY OR TOWN OF DEATH ANDREWS AIR FORCE BASE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MALCOLM GROW USAF MEDICAL CTR				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPERVISOR		12b. KIND OF BUSINESS OR INDUSTRY COKE-COLA CO.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND						13b. COUNTY PRINCE GEORGE		13c. CITY OR TOWN DISTRICT HEIGHTS		13d. INSIDE CITY LIMITS? Yes <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LESTER		15 MOTHER'S MAIDEN NAME FIRST MIDDLE SUSAN Wills		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO							
16b. SOCIAL SECURITY NO. \$79-03-3110		17. INFORMANT ADDRESS VIVIAN LENORA HARWELL/WIFE 7021 NIMITZ DRIVE, DISTRICT HEIGHTS									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>ARTERIO-SCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>DUE TO, OR AS A CONSEQUENCE OF</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CITIZENIC OBSTRUCTIVE PULMONARY DISEASE</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from <u>8 FEB</u> 19 <u>79</u> , to <u>8 FEB</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Thomas F. Qualey</u>		DEGREE MD		22c. DATE SIGNED 2/8/79				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS F. QUALEY, USAF, CAPTMD		22e. ADDRESS MALCOLM GROW USAF MEDICAL CENTER ANDREWS AIR FORCE BASE, MARYLAND, 20331									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-12-79		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G., Md.			
24 FUNERAL DIRECTOR NAME Funeral Home		24b. NAME Robt E Wilhelm		24c. ADDRESS 4308 Suitland Rd., Suitland, Md.				25a. DATE REC'D. BY REGISTRAR FEB 13 1979		25b. REGISTRAR'S SIGNATURE <u>Anthony M. Crady</u>	

BP

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 79-04927	
1. DECEASED NAME (TYPE OR PRINT) <i>Henry Herbert HALL Sr.</i>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <i>2-14</i> DAY <i>19</i> YEAR <i>79</i>		2b. HOUR <i>PM</i>			
3. SEX <i>Male</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH <i>11-15-23</i> MONTH <i>11</i> DAY <i>15</i> YEAR <i>23</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>55</i> YRS.		IF UNDER 1 YR. MONTHS <i></i> DAYS <i></i>		IF UNDER 24 HRS. HOURS <i></i> MIN <i></i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD.		
10. CITY OR TOWN OF DEATH <i>Cheverly</i>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prince George General</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Clerk</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Postal</i>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <i>Md/</i>		13b. CITY <i>Prince George District Hts.</i>		13c. CITY OR TOWN <i>Hts.</i>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS <i>6928 Walker Mill Road</i>			
14. FATHER'S NAME <i>Henson Hall</i>						15. MOTHER'S MAIDEN NAME <i>Ethel Tillman</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <i>Yes</i> (IF YES, GIVE WAR OR DATES) <i>WW II</i>				16b. SOCIAL SECURITY NO. <i>578 28 7699</i>		17. INFORMANT ADDRESS <i>Ethel Herring, Forestville, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac myopathy</i> <i>4254</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>Hepatic cirrhosis</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>August H. P. Rodriguez</i>				TITLE (SPECIFY) <i>Deputy</i> M.D.				MEDICAL EXAMINER DATE SIGNED <i>2-14-79</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>August H. P. Rodriguez</i>				ADDRESS <i>12800 W. 11th Wind Circle, Towson</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>2/17/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Washington Nat'l. Cem.</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Suitland, Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Robert G. Mason, Inc., Washington, D.C.</i> ADDRESS						25a. DATE REC'D. BY REGISTRAR <i>FEB 21 1979</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))  
15M/7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-04928

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Robert</b> FIRST <b>Z.</b> MIDDLE <b>HAZELL</b> LAST			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>2-13</b> DAY <b>13</b> YEAR <b>79</b>			2b. HOUR <b>9:53</b> M		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>1</b> DAY <b>2</b> YEAR <b>1970</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>10</b> YRS.	IF UNDER 1 YR. MONTHS <b>1</b> DAYS <b>13</b> HOURS <b>13</b> MIN.	7c. DATE PRONOUNCED DEAD <b>2-13</b> MONTH <b>13</b> DAY <b>13</b> YEAR <b>79</b>	7d. HOUR <b>9:53</b> M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Dash. D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES</b> MD.		
10. CITY OR TOWN OF DEATH <b>Chesley</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>P.G. Hospital (D.O.A.)</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter - Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>		13b. COUNTY <b>P. Georges</b>		13c. INSIDE CITY LIMITS? <b>YES</b> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>5408 Artoona Street</b>		
14. FATHER'S NAME FIRST <b>Robert</b> MIDDLE <b>Z.</b> LAST <b>Hazell, Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Adelaide</b> MIDDLE <b>Brewery</b> LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>578 01 1899</b>		17. INFORMANT ADDRESS <b>Mae Hazell, Wife, Same as Above</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Arterio Sclerotic Cardio Vascular Disease</b> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>		TITLE (SPECIFY) <b>DEPUTY</b>					DATE SIGNED <b>2-13 79</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>AUGUSTO P. RODRIGUEZ M. D.</b>		ADDRESS <b>12800 WILLOW WIND CIRCLE TANTALLON MARYLAND 20022</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2-16-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Brentwood, P.G., Md.</b> COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Robt E Wilhelm</b> ADDRESS <b>4308 Suitland Rd., Suitland, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 26 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony M. Bundy</b>		

MEDICAL CERTIFICATION

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UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										79-04929			
1- STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2b. DATE KNOWN OF DEATH			2c. DATE PRONOUNCED DEAD		2d. HOUR		
Robert Charles			HELANDER			2-20 1979			2-21 1979		2d. HOUR		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2d. HOUR	
Male		White		7-19-30		48 YRS.		MONTHS DAYS HOURS MIN		MONTH DAY YEAR		2d. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH			MD	
Illinois			USA			WIDOWED NEVER MARRIED XX DIVORCED			Prince Georges				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Cheverly			Prince Georges Hospital			Unemployed			none				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS	
Maryland			Pr. Georges			Hyattsville			YES XX NO			1403 Merrimac Drive,	
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST						FIRST MIDDLE LAST							
Robert Helander						Dorothy Mason							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS	
no				XXXXXX				216-30-4928				Louise Mason-Aunt-(same as 13e)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY.													
IMMEDIATE CAUSE													
42922 <i>Arteriosclerotic Cardiovascular disease with cardiomegaly.</i>													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.													
(b)													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
<i>Emaciation, colostomy sec. to perianal infection, Ethanol abuse</i>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20. AUTOPSY?	
												YES NO XX	
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				HOUR A.M. MONTH DAY YEAR									
				P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION					
								CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED					
<i>Augusto P. Rodriguez</i>				M.D. Deputy				MEDICAL EXAMINER				2/11/79	
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS									
Augusto P. Rodriguez				12800 Willow Wind Circle, Oxon Hill, Md. 20022									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Cremation				2-22-79		Metropolitan Crematory Alex.				Fairfax Va.			
24. FUNERAL DIRECTOR													
Warner E. Pumphrey, Inc. 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE													
4434 Ga. Ave., S.S. Md. FEB 26 1979													

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Items #10a-22a Film G530 1/6/79 re  
 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-04930

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MILDRED		MIDDLE L.		LAST HENEGHAN		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH 2		DAY 13		YEAR 79		2b. HOUR		M 11		A 14											
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 6 DAY 16 YEAR 20		6. AGE (IN YEARS) LAST BIRTHDAY 58 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD		MONTH 2		DAY 13		YEAR 79		A 14		M											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.																					
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Prince George's Co., Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY at home																					
13a. STATE Md.												13b. COUNTY Pr. Geo.				13c. CITY OR TOWN Suitland				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 3217 Sycamore La.									
14. FATHER'S NAME FIRST MIDDLE LAST Ollie King						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Wiggins						16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) none										16b. SOCIAL SECURITY NO. 237-34-1732				17. INFORMANT Jo Sandra Mount				ADDRESS 2154 D Waco La. AFB, Md. Andrews			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Atherosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF and imipramine intoxication Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE																					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>																																	
ACTUAL SIGNATURE <i>Margaret A. Korell</i>												TITLE (SPECIFY) Assistant				DATE SIGNED 2/14/79																	
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.						ADDRESS 111 Penn Street																											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 2/16/79				23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.						23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Fairfax Va.																	
24. FUNERAL DIRECTOR NAME G.P. Kalas												ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.				25a. DATE RECD. BY REG. CLERK FEB 21 1979						25b. SIGNATURE <i>[Signature]</i>											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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THE UNIVERSITY OF CHICAGO



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 79-04931			
1. DECEASED NAME (TYPE OR PRINT) <b>Maude DAVIES HICKS</b>										2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <b>2-27 1979</b>			
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>4</b> DAY <b>3</b> YEAR <b>1890</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>82</b> YRS.	IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>	2c. DATE PRONOUNCED DEAD MONTH <b>2</b> DAY <b>27</b> YEAR <b>1979</b>		2b. HOUR <b>4:19 P.</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Primer Georges</b>							
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PR. GEO. GEN. Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Milliner</b>					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. CITY OR TOWN <b>Primer Georges</b> 13c. CITY OR TOWN <b>Primer Georges</b>										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13. STREET ADDRESS <b>2414 Virginia Avenue Apt 201</b>	
14. FATHER'S NAME FIRST <b>Joseph</b> MIDDLE <b>STUMPNER</b> LAST <b>STUMPNER</b>				15. MOTHER'S MAIDEN NAME FIRST <b>JEANNETTE</b> MIDDLE <b>HICKS</b> LAST <b>HICKS</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>526-07-6440</b>		17. INFORMANT <b>Philip Stumpner (Brother)</b>				ADDRESS <b>3608 Hamilton St. Hyatts Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic selective Cardiovascular disease</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>				TITLE (SPECIFY) <b>M.D.</b>				DATE SIGNED <b>2-27-79</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez</b>				ADDRESS <b>17808 Wilkino Lane, Crofton, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (SEE IF) <b>CREMATION</b>		23b. DATE <b>3-1-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>				23d. LOCATION CITY OR TOWN <b>Suitland</b> COUNTY <b>P.G.</b> STATE <b>Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Francis Gasch's Sons F.H. P.A. Hyatts Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 5 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McCreedy</b>					

10-04931

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M  
(VR A15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-04932

1. DECEASED-NAME (Type or print) <b>JAMES DAVID HOUT</b>			2a. DATE OF DEATH <b>FEB</b> Month <b>13</b> Day <b>1979</b> or			2b. HOUR <b>9:33PM</b>			
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH <b>JAN 28, 1953</b>		6. AGE (In years last birthday) <b>26</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>GERMANY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>PRINCE GEORGES</b> Md.			
10. CITY OR TOWN OF DEATH <b>ANDREWS AFB MD</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MALCOLM GROW USAF MEDCEN</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>None</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>none</b>			
13a. USUAL RESIDENCE (Where deceased admission) STATE <b>MD</b>		13b. CITY OR TOWN <b>PRINCE GEORGES</b>		13c. CITY OR TOWN <b>BOWIE</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>12105 FOXHILL LANE</b>	
14. FATHER'S NAME First Middle Last <b>MARVIN JAMES HOUT</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>MARY LAVINA SMITH</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>227-64-8004</b>		17. INFORMANT <b>MARVIN J. HOUT (father)</b>		Address <b>SAME AS 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Duchenne's muscular dystrophy</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Congestive Failure</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>1200 13 Feb 79</b> , to <b>285 13 Feb 79</b> , that (I) (we) lost saw the deceased alive on <b>1200 13 Feb 79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Michael Daniels CAPT</b>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>13 Feb 79</b>			
22d. PHYSICIAN'S NAME (Type) <b>MICHAEL DANIELS, Capt, USAF, MC</b>				22e. ADDRESS <b>MALCOLM GROW USAF MEDICAL CENTER ANDREWS AFB MD 20331</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>Feb. 17, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Alexandria, Virginia</b>			
24. FUNERAL DIRECTOR <b>Robert G. Beall Funeral Home</b>				ADDRESS <b>9013 Annapolis Road, Lanham, Maryland</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 21 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia McCready</b>	

10-04335



UNITED STATES  
DEPARTMENT OF JUSTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Medical Examiner Notified 2/3/79

# STATE OF MARYLAND

## DEPARTMENT OF HEALTH AND MENTAL HYGIENE

### CERTIFICATE OF DEATH

79-04933

1. DECEASED-NAME (Type or print) <b>Alexandros M. Hronakis</b>			2a. DATE OF DEATH Month <b>February</b> Day <b>3</b> Year <b>1979</b>		2b. HOUR <b>10:00</b> AM
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>January 20, 1893</b>		6. AGE (In years last birthday) <b>86</b> YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Greece</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince George's</b> Md.		
10. CITY OR TOWN OF DEATH <b>Cheverly</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo's General Hospital</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Cook (Empld)</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Arundel</b>	13c. CITY OR TOWN <b>P.O. Upper Marlboro</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>Box L</b>	
14. FATHER'S NAME First <b>UNKNOWN</b> Middle <b>UNKNOWN</b> Last <b>UNKNOWN</b>			15. MOTHER'S MAIDEN NAME First <b>UNKNOWN</b> Middle <b>UNKNOWN</b> Last <b>UNKNOWN</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) <b>--</b>		16b. SOCIAL SECURITY NO. <b>227-14-8724</b>	17. INFORMANT <b>Daniel Boone Wayson-Upper Marlboro, Md. 20870</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>August, 1978</b> to <b>Feb 3, 1979</b> , that (I) (we) last saw the deceased alive on <b>1/29</b> <b>1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>A. Clark Holmes</b>		DEGREE <b>MD.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2/3/79</b>	
22d. PHYSICIAN'S NAME (Type) <b>A. Clark Holmes, M.D.</b>		22e. ADDRESS <b>Upper Marlboro, Maryland 20870:</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>2/8/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lakemont Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Davidsonville (A.A.) Md.</b>	
24. FUNERAL DIRECTOR <b>Richard A. Coleman-Upper Marlboro, Maryland 20870:</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 6 1979</b>		25b. REGISTRAR'S SIGNATURE <b>W. H. McCurdy</b>	

18-04333

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-04934	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELIZA B HUNT						2a. DATE OF DEATH MONTH DAY YEAR 2 9 79			2b. HOUR 6:35A M		
3. SEX FEMALE		4. RACE NEGRO		5. DATE OF BIRTH MONTH DAY YEAR Feb 3 1904		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Gretna, Virginia		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.					
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GEN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic			12b. KIND OF BUSINESS OR INDUSTRY Pvt.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD.		13b. COUNTY P. G.		13c. CITY OR TOWN Palmer Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1806 Ray LEONARD ROAD			
14. FATHER'S NAME FIRST MIDDLE LAST unknown Hunt						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Adelaide Carter					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 232-52-8108		17. INFORMANT Mrs. Pauline Robinson		ADDRESS Palmer Park, MD. 1806 Ray Leonard Road.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Diabetes Mellitus c 2500 DUE TO, OR AS A CONSEQUENCE OF (b) Peripheral vascular disease (c) DUE TO, OR AS A CONSEQUENCE OF ② Prob BK Amp of Rt leg and AK Amputation of L. leg PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ③ Decubitus ulcers										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 10:30 19 78, to 2:9 19 79, that (I) (we) last saw the deceased alive on 2:9 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE H. A. Molavi M.D.						DEGREE M.D.		22c. DATE SIGNED 2.9.79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. A. Molavi, M.D.						22e. ADDRESS 6005 Landover Rd Cheverly, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 13, 1979		23c. NAME OF CEMETERY OR CREMATORY Harmony Cemetery		23d. LOCATION CITY OR TOWN Landover		COUNTY STATE PG. Maryland			
24. FUNERAL DIRECTOR NAME Rollins Funeral Home, Inc. ADDRESS 4339 Hunt Pl. N.E.						25a. DATE REC'D BY REGISTRAR FEB 14 1979		25b. REGISTRAR'S SIGNATURE [Signature]			



18840-27

AC13

PRINCE GEORGE'S GEN HOSPITAL

CHENRY



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-04935	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>JOHN HUFF</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>February 21 1979</b>		2b. HOUR <b>5:55 P</b>			
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 21 1889</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George</b> MD.					
10. CITY OR TOWN OF DEATH <b>Greenbelt</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greenbelt Convalescent Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Greenbelt</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Not Available</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Austin A. Huff</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Anne Williams</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>235-12-8528</b>		17. INFORMANT ADDRESS <b>Ralph R. Huff-Foster Son</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4292 } DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTEROSCLEROTIC CARDIOVASCULAR DISEASE</b>										11 YEARS	
} DUE TO, OR AS A CONSEQUENCE OF (c) <b>GENERALIZED ARTEROSCLEROSIS</b>										11 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>4/25 1969</b> to <b>2/22/79</b> , that <del>the</del> (we) lost <del>now the deceased</del> alive on <b>1/14 1979</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> (I) did <del>not</del> view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>2/22/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERTO DEPETRIS MD</b>		22e. ADDRESS <b>6776 RACE TRACK RD BARWIE MD 20715</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2-25-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Broad Run Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Jane Lew, West Virginia</b>					
24. FUNERAL DIRECTOR NAME <b>Metropolitan Funeral Service</b> ADDRESS <b>5517 Vine Street Alexandria, Virginia</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 27 1979</b>		25b. REGISTRAR'S SIGNATURE					

20040-05

20040-05

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 79-04936																			
1. DECEASED NAME (TYPE OR PRINT) <b>Howard L. HUNT Jr</b>										2a. DATE KNOWN OF DEATH ESTIMATED <b>2-21 1979</b>										2b. HOUR <b>4:30</b>																													
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>12-22-18</b>		6. AGE (IN YEARS) <b>60 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD <b>2-21 1979</b>										2d. HOUR <b>4:30</b>																											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>										7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b>																			
10. CITY OR TOWN OF DEATH <b>Lanham</b>										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN CITY OR COUNTY OF DEATH) <b>Doctors Hospital of P.G.</b>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Lab. Supervisor</b>										12b. KIND OF BUSINESS OR INDUSTRY <b>E.P.A.</b>																			
13a. STATE <b>Md.</b>										13b. COUNTY <b>P.G.</b>										13c. CITY OR TOWN <b>Greenbelt</b>										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS <b>58 J Crescent Rd.</b>									
14. FATHER'S NAME <b>Howard Lodge Hunt</b>										15. MOTHER'S MAIDEN NAME <b>Edna E. Propst</b>										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <b>Yes</b>										16b. SOCIAL SECURITY NO. <b>273-05-1837</b>										17. INFORMANT ADDRESS <b>Virginia L. Hunt, Same as # 13</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Cardiovascular disease</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>																													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION STREET CITY OR TOWN COUNTY STATE																													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										TITLE (SPECIFY) <b>Deputy</b>										DATE SIGNED <b>2-22-79</b>																													
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>										MEDICAL EXAMINER										EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez</b>										12800 Wallow Wind Circle, Oxon Hill, Md. 20022																			
23a. BURIAL, CREMATION, REMOVAL (BY CITY) <b>Burial</b>										23b. DATE <b>2-28-79</b>										23c. NAME OF CEMETERY OR CREMATORY <b>Woodland Cemetery</b>										23d. LOCATION CITY OR TOWN COUNTY STATE <b>VanWert, VanWert, Ohio</b>																			
24. FUNERAL DIRECTOR <b>F. Gasch's Sons, P. A.</b>										ADDRESS <b>Hyattsville, Md.</b>										25a. DATE REC'D. BY REGISTRAR <b>FEB 26 1979</b>										25b. REGISTRAR'S SIGNATURE																			

70-04930

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

TO: DIRECTOR, FBI (100-371101) FROM: SAC, NEW YORK (100-100000) (P)

SUBJECT: [REDACTED] (NY 100-100000) (P)

RE: [REDACTED] (NY 100-100000) (P)

DATE: 10-10-60 (NY 100-100000) (P)

5-55-5

ONLY

100-100000 (NY 100-100000) (P)

100-100000 (NY 100-100000) (P)

100-100000 (NY 100-100000) (P)

100-100000 (NY 100-100000) (P)

100-100000 (NY 100-100000) (P)

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-04937  
REG. NO.

FOR 1- STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										79-04937 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR					
FRANK GEORGE		Hutchison						2-19		19		79				M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
MALE		WHITE		2-3-29		49 YRS.						2-19		19		79				P:12 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
Washington DC		U.S.A						PRINCE GEORGES													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
CHEVERLY		PRINCE GEORGES GEN. HOSP. (DOA)		Southern Railroad		Railroad															
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS															
MARYLAND		PRINCE GEORGES		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5405 TRENT Street															
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																			
Abraham Franklyn Hutchison		Alma Schwebel																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS															
NO		578-38-0494		John F. Simpson Jr.		525 University Dr. Waldorf, Md															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4254 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		CARDIOMYOPATHY		DUE TO, OR AS A CONSEQUENCE OF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
				(b)		DUE TO, OR AS A CONSEQUENCE OF															
				(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		HEPATIC CIRRHOSIS																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?																	
				YES <input type="checkbox"/> NO <input type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE																	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE		DEPUTY M.D.		MEDICAL EXAMINER		DATE SIGNED															
EXAMINER'S NAME (TYPE OR PRINT)		AUGUSTO P. RODRIGUEZ, M.D.		12800 Willow Wind Circle		Tantallon															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE															
Cremation		2/21/79		Cedar Hill Crematory		Seitzland, Prince Georges Co. Md.															
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
George P. Kaks		T.H. 6160 Glen Hill Rd. Overland Park, Mo		FEB 25 1979		Anthony McCready															

10-04337

10-04337

10-04337



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-04938

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>A.K.A. Katie</b> <b>KATRINA P. JAMES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>02-04-79</b>			2b. HOUR <b>2:45AM</b>			
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9-16-1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGE'S GEN. HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>----</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>			13b. COUNTY <b>Prince Geo.</b>		13c. CITY OR TOWN <b>Mar Dr.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Oillie Parks</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maude Hellem</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>----</b>		17. INFORMANT NAME ADDRESS <b>Betty Williams S.A.A.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4249</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic CHF</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Valvular heart disease</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>post embolism for left leg arterial embolism</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>1-28-77</b> to <b>1-4-79</b> , that (I) (we) last saw the deceased alive on <b>1-4-79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>H. A. Molavi, M.D.</b>						DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>2.5.79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>H. A. Molavi, M.D.</b>						22e. ADDRESS <b>6005 Landoover Rd Cheverly, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>XXX</b>			23b. DATE <b>I-10-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln, Mem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Frazier Funeral Home</b>						ADDRESS <b>389 R.I. Ave N.W.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 1 1979</b>	
						25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

80040-01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-04939	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>BESSIE M. JOHN</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>02 01 79</b>		2b. HOUR <b>10:10PM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 2, 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES COUNTY MD.</b>					
10. CITY OR TOWN OF DEATH <b>Laurel</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GREATER LAUREL BELTSVILLE HOSPITAL</b>				12a. OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Dept of Agr.</b>		12b. INDUSTRY OF BUSINESS OR INDUSTRY <b>Government</b>			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Prince Geo</b>		13c. CITY OR TOWN <b>Beltsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1545 C 46th Ave. Apt 204</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Maloney</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Roberta Atkins</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>579 24 0185</b>		17. INFORMANT <b>Marjorie R. Eby</b>		17a. ADDRESS <b>9749 Goodluck Rd Seabrook, Md.</b>		17b. RELATIONSHIP <b>(Daughter)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive acute myocardial infarction</b> 410- DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>2/1/79</b> 19 <b>79</b> , to <b>2/11</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>2/1/79</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Robert S. McCeney M.D.</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/1/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT S. MCCENEY M.D.</b>						22e. ADDRESS <b>402 Main Street Laurel, Maryland 20810</b>					
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>			23b. DATE <b>Feb. 5, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood Prince Geo Md.</b>			
24. FUNERAL DIRECTOR'S NAME <b>Frank J. Gassch's Sons Funeral Home, P.A.</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 6 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Anthony McCreedy</i>			
24a. ADDRESS <b>Hyattsville, Maryland</b>											

72-04933

#8 85293/12/79 gj

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04940

1. DECEASED NAME (TYPE OR PRINT) <b>Fred E. Jolie</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>2/2/1979</b>		2b. HOUR <b>6:30 PM</b>	
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7/29/1886</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>93</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Orleans</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b> MD.	
10. CITY OR TOWN OF DEATH <b>Forestville, Md</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Regency Nursg + Rehab.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>U.S. Gov.-Ret.</b>	
13a. STATE <b>D.C.</b>		13b. COUNTY <b>Washington</b>		13c. STREET ADDRESS <b>5920 3rd St. N.W.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>579-56-7904</b>		17. INFORMANT <b>Ruth Jolie-Wife</b>	
				ADDRESS <b>1810 Vermont Ave. N.W. Washington, D. C.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4275</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
--	--	---

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>12-28-78</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>12-28-78</b> 19 <b>78</b> , to <b>2-2</b> 19 <b>79</b> , that (I) (we) (we) last saw the deceased alive on <b>2-2-79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>John F. Shoy</b>		22c. DATE SIGNED <b>2-2-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/7/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Landover, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Morrow &amp; Woodford, Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 8 1979</b>			
ADDRESS <b>1622 11th. St. NW</b>				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

BP \_\_\_\_\_

DHMH - 16 50M 7/77  
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

73-04940

U.S. Gov.-Pat.

1810 Vermont Ave. N.W.  
Washington, D. C.

x

Indoor, N.

Interior, N.

2/17/79

Initial

Worow & Woodford, Inc. 1000 11th St. N.W.



BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-04941	
1. DECEASED NAME (TYPE OR PRINT) <b>FREEMAN, LEONARD JONES</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 20 1979</b>		2b. HOUR <b>1015 AM</b>			
3. SEX <b>MALE</b>		4. RACE <b>CAU</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 6 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>DENISON, TEXAS</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES COUNTY MD.</b>					
10. CITY OR TOWN OF DEATH <b>ANDREWS AF BASE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MALCOLM GROW USAF MEDICAL CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MILITARY</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>US AIR FORCE</b>			
13a. STATE <b>VIRGINIA</b>		13b. COUNTY <b>FAIRFAX</b>		13c. CITY OR TOWN <b>ALEXANDRIA</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>8316 BOUND BROOK LANE</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>LEONARD I JONES</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELIZABETH NMI CHRISTMAN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>FEB 1942</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>AUG 1968</b>		17. INFORMANT <b>LOIS M. JONES (WIFE)</b>		ADDRESS <b>8316 BOUND BROOK LANE ALEXANDRIA, VA 22309</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardio pulmonary failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Stage D Carcinoma of Pancreas</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION <b>17 Nov 79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma of Pancreas</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>6 Nov 78</b> , to <b>20 Feb 79</b> , that (I) (we) last saw the deceased alive on <b>20 Feb 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE <b>Kenneth A. Clark</b> DEGREE				22c. DATE SIGNED <b>20 Feb 79</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KENNETH A. CLARK, MAJ, USAF, MD</b>				22e. ADDRESS <b>MALCOLM GROW USAF MEDICAL CENTER ANDREWS AFB DC 20331</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2-24-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Georgetown Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Georgetown, Texas</b>					
24. FUNERAL DIRECTOR NAME <b>Demaine Funeral Home</b> ADDRESS <b>Alexandria, Va 22314</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 26 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Barney McCready</b>					



10-01341

I

WILSON GROU USAF MEDICAL CENTER  
ANDREWS AFB DC 20331

RENEE A. CLARK, MD, USAF, MD

10-01341

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 79-04942	
1. DECEASED NAME (TYPE OR PRINT) <b>Foad Kenyada Jordan</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>2 19 1979</b>		2b. HOUR <b>M</b>			
3. SEX <b>female</b>	4. RACE <b>black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11-20-75</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>3 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>2 19 1979</b>		7d. HOUR <b>10:34 a. M</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George County MD.</b>					
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince George General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NONE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>P G. County</b>		13c. CITY OR TOWN <b>Bladensburg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8148 Allendale Drive</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Donnell Adams</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Charlena Jordan</b>			16. ADDRESS <b>106</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>UNKNOWN</b>		17. INFORMANT <b>Charlena Jordan - Mother / 5200 Quincy St. #10</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Smoke Inhalation</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <b>8902</b> (b) <b>DUE TO, OR AS A CONSEQUENCE OF</b> (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>8:30 P.M. 2/19 1979</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>housefire</b>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>house</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>8148 Allendale Drive, PalmerPk, P.G.Co. Md.</b>						
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Virginia L. Dolan</b>			TITLE (SPECIFY) <b>Assistant</b>			MEDICAL EXAMINER		DATE SIGNED <b>2/22/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>			ADDRESS <b>111 Penn Street, Balto, MD 21201</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>2/24/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CHURCH CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>MAXTON, NORTH CAROLINA</b>				
24. FUNERAL DIRECTOR NAME <b>JOHN T. RHINES CO.</b>					25a. DATE REC'D. BY REGISTRAR <b>MAR 2 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McCreedy</b>				

54010-05

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-04943	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDWARD C. KAIGHN					2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 16, 1979			2b. HOUR 5:00A M			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR April 2, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 85 years YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.					
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of P. G. County				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Post Master		12b. KIND OF BUSINESS OR INDUSTRY U S Post office			
13a. STATE Md					13b. COUNTY Pro Georges		13c. CITY OR TOWN Greenbelt		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST James Barton Kaighn					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Sharp						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes W W 1		16b. SOCIAL SECURITY NO. 577 26 1152		17. INFORMANT ADDRESS Adelaide P Kaighn Greenbelt, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>old perforated duodenal ulcer, lactic acidosis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>4/5</u> , 19 <u>79</u> , to <u>2/16</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE D. Granite MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/16/79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. Granite MD					22e. ADDRESS 115 Centerway Greenbelt, Md						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb 19, 1979		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pro Georges Md					
24. FUNERAL DIRECTOR NAME F. Gasch's Sons P A Hyattsville, Md.					25a. DATE REC'D. BY REGISTRAR FEB 25 1979		25b. REGISTRAR'S SIGNATURE [Signature]				

13-04913

STATE OF NEW YORK  
IN SENATE  
January 11, 1911

REPORT  
OF THE  
COMMISSIONERS OF THE  
LAND OFFICE  
IN RESPONSE TO A  
RESOLUTION PASSED  
BY THE SENATE  
JANUARY 11, 1911

ALBANY: J.B. LEECH, STATE PRINTER, 1911.

ALBANY: J.B. LEECH, STATE PRINTER, 1911.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 79-04944				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST IVAN L. KAJZOVAR					2a. DATE OF DEATH MONTH DAY YEAR 02-16-79			2b. HOUR 7:10 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec 23 1916		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Austria		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk, U.S. Gov't.		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Forestville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2716 Kirtland Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Leopold Kajzovar					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria ?				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 42 1540		17. INFORMANT ADDRESS Silva D. Kajzovar, Wife, Same as Above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Failure + Respiratory arrest</u> 5715 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Portal Cushing + Portal Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12-15-78</u> , to <u>2-16-79</u> , that (I) (we) last saw the deceased alive on <u>2/16/79</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Leroy Cohen</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/16/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEROY COHEN MD.					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-20-79		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton, P.G., Md.			
24. FUNERAL DIRECTOR NAME Robt E Wilhelm Funeral Home Rd., Suitland, Md.					25a. DATE REC'D. BY REGISTRAR FEB 22 1979		25b. REGISTRAR'S SIGNATURE <u>Henry McCreedy</u>		

10-04944

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C. 20535

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		79-04945						REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
GERARD GABRIEL KEMP		XXXXX		XXXXX		XXXXX		FEBRUARY 25, 1979		1:25P M	
3 SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		Cauc.		June 25, 1902		76 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Mass.		U.S.A.				PRINCE GEORGE COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
LANHAM		DOCTORS HOSP. OF P.G. CO.						Teacher & Commander		Navy	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Pri. Georges		Bowie		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		16315 Pond Meadow Lane			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Joseph Kemp				Catherine O'Reilly							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
yes				1941-1963		Elizabeth S. Kemp, 16315 Pond Meadow Lane, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <i>Electrolyte im. Balance</i>										4.5 hr	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cardiac failure</i>										1 WK	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic congestive failure</i>										10 ph days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
<i>Chronic Hepatic Disease</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb 25</i> , 19 <i>77</i> , to <i>Feb 25</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>Feb 25</i> , 19 <i>77</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) had a view of the body after death.											
22b. SIGNATURE <i>John J. Shigo</i>				DEGREE				22c. DATE SIGNED <i>Feb 26 1979</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
JOHN J. SHIGO, M.D.				6911 Laurel Bowie Rd, Bowie, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		Feb. 28, 1979		Resurrection Cemetery		Clinton, Maryland					
24. FUNERAL DIRECTOR'S NAME (TYPE OR PRINT)						25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert G. Beall Funeral Home 9013 Annapolis Road, Lanham, Maryland						MAR 2 1979		<i>History McCready</i>			

BY FUNERAL DIRECTOR

ADDRESS

25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

24040-07

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMM-16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR 1. STATE REGISTRAR		79-04946							
1. DECEASED NAME (TYPE OR PRINT)		FIRST NELLIE		MIDDLE W		LAST KERN		2a. DATE OF DEATH MONTH DAY YEAR 2 12 79	
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jan. 1, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7b. HOUR 12:25 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.			
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GEN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Virginia		13b. COUNTY Frederick		13c. CITY OR TOWN Gainesboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Bloomery Star Route	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph W. Lee				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Brown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-42-5664		17. INFORMANT ADDRESS Mrs. Lawrence Sine 4405 Powder Mill Rd. Beltsville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic vascular disease</u> 20 yrs. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>2/1/79</u> , 19 <u>79</u> , to <u>2/12/79</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>2/1/79</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)									
22b. SIGNATURE <u>Frederick E. Musser MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>2/12/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Frederick E. Musser MD</u>				22e. ADDRESS <u>4410 74th Ave. Hyattsville 20785</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 15, 1979		23c. NAME OF CEMETERY OR CREMATORY Gainesboro Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Gainesboro, Virginia			
24. FUNERAL DIRECTOR NAME Capitol Funeral Service				25a. DATE REC'D. BY REGISTRAR FEB 16 1979		25b. REGISTRAR'S SIGNATURE <u>Patricia Beatty</u>			

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1, 2, AND 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 04947

1- FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH										2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margorie Huckstep King										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 25 1979										2b. HOUR 7:00 AM	
3 SEX Female		4 RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 10-26-1909		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 25 1979				7d. HOUR 7:00 AM					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.									
10. CITY OR TOWN OF DEATH Suitland				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Apt. 605, 2100 Brooks Drive								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired				12b. KIND OF BUSINESS OR INDUSTRY Insurance					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																					
13a. STATE Maryland		13b. CITY OR TOWN Prince Georges Suitland		13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								13e. STREET ADDRESS Apt. 605, 2100 Brooks Dr.							
14. FATHER'S NAME FIRST MIDDLE LAST William Jackson Huckstep										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Mozella Jarrell											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 223-01-6008				17. INFORMANT ADDRESS Mrs Henry J. Smith Madison, Va													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cranio-Cerebral Injuries</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 5 <del>xxx</del> 1 25 1979				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5 <del>xxx</del> 1 25 1979				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject struck on head													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home				21f. LOCATION Apt. 605, 2100 Brooks Dr., Suitland, Prince George's, MD													
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE <u>Virginia L. Dolan</u>				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER				DATE SIGNED 1/25/79									
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1-27-79		23c. NAME OF CEMETERY OR CREMATORY Rochelle Christian				23d. LOCATION CITY OR TOWN COUNTY STATE Rochelle Madison, Va.											
24. FUNERAL DIRECTOR NAME ADDRESS Clore Funeral Home, Culpeper, Va.										25a. DATE REC'D. BY REGISTRAR FEB 8 1979		25b. REGISTRAR'S SIGNATURE [Signature]									

BP

54840-85



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-04948			
1. FOR STATE REGISTRAR					2a. DATE OF DEATH					MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST					02- 05- 79		11:26 AM	
VISHNU D. KHURANA													
3 SEX		4 RACE		5 DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		East Indian		June 30, 1901		77		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
India		India				PRINCE GEORGE'S COUNTY MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
CHEVERLY		PRINCE GEORGE'S GEN. HOSPITAL				Ret. Professor-Jamestown College							
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Maryland					Prince George Riverdale				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6404-63rd Place		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME								
FIRST MIDDLE LAST					FIRST MIDDLE LAST								
L Attar Chand					Vidya Vata								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS			
No					502 60 2094		Vinod Khurana-son			Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA													
4148 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
(b) CORDONARY ARTERY DISEASE													
DUE TO, OR AS A CONSEQUENCE OF													
(c) OLD INFERIOR WALL MYOCARDIAL INFARCTION													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
CEREBRO VASCULAR ACCIDENT													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
None								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2-5, 19 79 to 2-5, 19 79, that (I) (we) lost saw the deceased alive on 2-5, 19 79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE				DEGREE				22c. DATE SIGNED					
VP Singh				M.D.				2.6.79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS									
VIRENDER P. SINGH				5700 EAST WEST HIGHWAY #100 HYATTSVILLE Md, 20782									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Cremation				Feb. 7, 1979		Lee's Crematory		Washington, D.C.					
24. FUNERAL DIRECTOR NAME								25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
J.Wm. Lee's Sons Co., 300-4th Sts., NE, Wash., D.C.								FEB 9, 1979		[Signature]			





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										79-04949	
1- FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BONG CHUL KIM										2e. DATE KNOWN OF DEATH ESTI-MATED 1979 February 21 6:45 PM	
3. SEX Female	4. RACE Korean	5. DATE OF BIRTH MONTH DAY YEAR Nov. 24, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD 19 M		7d. HOUR		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Korea		7b. CITIZEN OF WHAT COUNTRY? Korea			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD				
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors Hospital of Prince Geo.Co.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Landover		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6824 Shepherd Street			
14. FATHER'S NAME FIRST MIDDLE LAST (Unknown)					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (Unknown)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. --		17. INFORMANT ADDRESS 6901 Stanish Drive Indong Kim-Landover, Maryland						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> 3500 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Diabetes mellitus</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Urinary Tract Infection</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE YEAR-Kwon H. Yoon				TITLE (SPECIFY) M.D. M.D.				DATE SIGNED 2/21/79			
EXAMINER'S NAME (TYPE OR PRINT) YEAR-Kwon H. Yoon				ADDRESS 5506 Kenilworth Ave. Riverdale							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 24, 1979		23c. NAME OF CEMETERY OR CREMATORY Md. Nat'l. Mem'l. Park				23d. LOCATION CITY OR TOWN Laurel - Prince Geo. - Md.			
24. FUNERAL DIRECTOR NAME Chambers Funeral Home - Riverdale, Maryland						25a. DATE REC'D. BY REGISTRAR FEB 28 1979		25b. REGISTRAR'S SIGNATURE Hofny McBrady			

18-04948

NEW YORK STATE DEPARTMENT OF CORRECTIONS  
ALBANY, NEW YORK



TO :	NEW YORK STATE DEPARTMENT OF CORRECTIONS ALBANY, NEW YORK
FROM :	NEW YORK STATE DEPARTMENT OF CORRECTIONS ALBANY, NEW YORK
SUBJECT :	NEW YORK STATE DEPARTMENT OF CORRECTIONS ALBANY, NEW YORK
RE :	NEW YORK STATE DEPARTMENT OF CORRECTIONS ALBANY, NEW YORK
DATE :	NEW YORK STATE DEPARTMENT OF CORRECTIONS ALBANY, NEW YORK
BY :	NEW YORK STATE DEPARTMENT OF CORRECTIONS ALBANY, NEW YORK
APPROVED :	NEW YORK STATE DEPARTMENT OF CORRECTIONS ALBANY, NEW YORK
REMARKS :	NEW YORK STATE DEPARTMENT OF CORRECTIONS ALBANY, NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 79-04950			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME FIRST MIDDLE LAST FRANKLIN PIERCE KIMMEL				FEB 22 1979 11:08p.m.			
3 SEX MALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR OCT 8 1902		6 AGE (IN YEARS LAST BIRTHDAY) 76	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, DC		7b. CITIZEN OF WHAT COUNTRY? US		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.	
10 CITY OR TOWN OF DEATH ANDREWS AFB		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MALCOLM GROW USAF MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY ICE CREAM CO.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY PRINCE GEORGE 13c. CITY OR TOWN CAMP SPRINGS				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4604 BRINKLEY ROAD	
14 FATHER'S NAME FIRST MIDDLE LAST HARRY O. KIMMEL				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GRACE NMI KULIMAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. NA		17. INFORMANT ADDRESS JUNIUS C. STEEN 4604 BRINKLEY RD CAMP SPRING			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410- CAROTID ARTERY (b) DUE TO, OR AS A CONSEQUENCE OF (Arterial) MI (c) DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Feb 22, 19 79, to Feb 22, 19 79, that (I) (we) last saw the deceased alive on Feb 22, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Thomas R. Kelly M.D.				DEGREE		22c. DATE SIGNED Feb 22, 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas R. Kelly				22e. ADDRESS MALCOLM GROW USAF MEDICAL CENTER ANDREWS AFB, MARYLAND 20332			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-26-1979		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.	
24 FUNERAL DIRECTOR NAME George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill Maryland				25a. DATE RECD. BY REGISTRAR Feb 26 1979		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

02240-07



NAME	POSITION	STATUS	REMARKS
JOHN D. SMITH	CHIEF	ACTIVE	
JANE E. BROWN	SECRETARY	ACTIVE	
WILLIAM R. GREEN	CLERK	ACTIVE	
MARY K. WHITE	RECEPTIONIST	ACTIVE	
ROBERT L. BLACK	WATCHMAN	ACTIVE	
CHARLES F. GRAY	MAINTENANCE	ACTIVE	
EDWARD G. HILL	PROPERTY	ACTIVE	
HELEN M. JONES	ADMINISTRATIVE	ACTIVE	
FRANK J. KELLY	SECURITY	ACTIVE	
ALICE S. LYNN	TRAINING	ACTIVE	

1. The purpose of this document is to provide a comprehensive overview of the organization's current status and future plans.

2. The organization has achieved significant milestones in the past year, including the successful completion of the new building project and the launch of the new product line.

3. The following table provides a detailed breakdown of the organization's financial performance over the last five years.

4. The organization is committed to maintaining high standards of ethical conduct and transparency in all its operations.

5. The future plans for the organization include expanding into new markets and investing in research and development to stay at the forefront of the industry.

6. The organization's success is dependent on the dedication and hard work of its employees, and we are grateful for their contributions.

7. The organization is also committed to social responsibility and environmental sustainability, and we will continue to strive for excellence in these areas.

8. The organization's vision is to become a global leader in its field, and we are confident that our strategic plan will achieve this goal.

9. The organization's values are integrity, innovation, and excellence, and we will continue to uphold these values in all our actions.

10. The organization's mission is to provide high-quality products and services to our customers, and we are committed to exceeding their expectations.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 79-04951					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARION ABNEY KITCHEN										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 2-18 19 79		2b. HOUR M			
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 4-21-10		6. AGE (IN YEARS) LAST BIRTHDAY 68 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2-18 19 79		2d. HOUR M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES			
10. CITY OR TOWN OF DEATH CHEVERLY				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GEN. HOSP. (DOA)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret.				12b. KIND OF BUSINESS OR INDUSTRY -----	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE MARYLAND		13b. COUNTY PRINCE GEORGES		13c. CITY OR TOWN LANDOVER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2715 HAWTHORNE TERRACE							
14. FATHER'S NAME FIRST MIDDLE LAST Charlie Abney						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Berch									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. -----		17. INFORMANT ADDRESS Junita West Neice 2715 Hawthorne Terr. Landover, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE Augusto P. Rodriguez				TITLE (SPECIFY) DEPUTY M.D.				MEDICAL EXAMINER 12800 WILLOW WIND CIRCLE, TANTALLON, MD. 20022				DATE SIGNED 2-20-79			
EXAMINER'S NAME (TYPE OR PRINT) AUGUSTO P. RODRIGUEZ M. D.				ADDRESS											
23a. BURIAL, CREMATION, REMOVAL XXX				23b. DATE 2-27-79		23c. NAME OF CEMETERY OR CREMATORY Nat. Harmony Cem.				23d. LOCATION CITY Landover, Md.				STATE	
24. FUNERAL DIRECTOR NAME Frazier						389 R.I. Ave N.W. Wash., D.C.						25a. DATE REC'D. BY REGISTRAR MAR 2 1979		25b. REGISTRAR'S SIGNATURE Henry McCreedy	



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14  
DIVISION OF VITAL RECORDS, 701 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-04952							
1. FOR STATE REGISTRAR				REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ARCHER Frank KODAMA				2a. DATE OF DEATH MONTH DAY YEAR 02 10 79				2b. HOUR 8:54PM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Dec. 3, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGESS MD.					
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mgmt, Analyst Control Data Corp		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Seabrook		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9789 Good Luck Rd. # 3	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Kodama				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Forty							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 263 24 5214		17. INFORMANT ADDRESS Mildred Kodama Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4149 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe coronary artery disease</u> (c) <u>years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>JAN 76</u> , 19 <u>76</u> , to <u>FEB 10</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>FEB 9</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE David M. Goldman				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/12/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David M. Goldman, MD				22e. ADDRESS 6525 Belcrest Rd. Hyattsville, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 13 FEB 79		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Va.			
24. FUNERAL DIRECTOR NAME Robert G. Beall Funeral Home				25a. DATE REC'D. BY REGISTRAR FEB 15 1979		25b. REGISTRAR'S SIGNATURE [Signature]					
1212 West St. Annapolis, Md. 21401											

10-01225

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535



TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK (100-100000)  
SUBJECT: [Illegible]  
RE: [Illegible]  
DATE: [Illegible]  
CLASSIFICATION: [Illegible]  
[Illegible text continues]

[Large block of illegible text, likely a memorandum or report body.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										79-04953 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>JEROME D. KROHNFELDT</b>										2a. DATE KNOWN OF DEATH ESTIMATED <b>2-20 1979 6P.M.</b>										2b. HOUR	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>10</b> DAY <b>6</b> YEAR <b>33</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>45</b> YRS.		IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b>		2c. DATE PRONOUNCED DEAD <b>2-20 1979 6P.M.</b>		2d. HOUR									
7a. BIRTHPLACE (STATE OR TERRITORY) <b>Minnesota</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD.									
10. CITY OR TOWN OF DEATH <b>Laurel</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF IN BALTIMORE, GIVE STREET ADDRESS) <b>11907 Orvis Way</b>				12a. USUAL OCCUPATION (TYPE OF WORK) <b>Intelligence Officer</b>				12b. NATIONAL BUSINESS <b>National Security Agency</b>									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																					
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince Geo.</b>		13c. CITY OR TOWN <b>Laurel</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>11907 Orvis Way</b>													
14. FATHER'S NAME -- FIRST -- MIDDLE -- LAST <b>Reinhart Krohnfeldt</b>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ann Gustafson</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>472 30 8437</b>				17. INFORMANT <b>M. Mildred Krohnfeldt Same as #13 (Wife)</b>				ADDRESS									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic carcinoma</b> 5715- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>				TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER				DATE SIGNED <b>2-20-79</b>									
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez</b>				ADDRESS <b>12800 Willow Wind Circle, Oxon Hill, Md. 20022</b>																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>2/24/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Alexandria Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria Douglas Minn.</b>											
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland</b>																					
25a. DATE REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>																	

0201  
BP

82840-97

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04954

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1 DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
WILLIAM G. LAURICH		MALE		WHITE	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. BALTIMORE CITY OR COUNTY OF DEATH	
MONTH DAY YEAR APRIL 3, 1919		59 YRS		PRINCE GEORGE'S	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
PENNSYLVANIA		U.S.A.		PRINCE GEORGE'S	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
CHEVERLY		PRINCE GEORGE'S GENERAL HOSPITAL		VICE PRINCIPAL	
13a. STATE		13b. COUNTY		13c. STREET ADDRESS	
MARYLAND		PRINCE GEO.		5627 ELBERTON PLACE	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
ANTON		ELIZABETH		YES	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiopulmonary insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>coronary atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d) <u>3/4 Whipple Procedure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
1/20/79		Carcinoma of the pancreas		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1/20/79</u> to <u>1/21/79</u> , that (I) (we) last saw the deceased alive on <u>1/20/79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Jerome L. Sandler</u>		22c. DATE SIGNED <u>1/21/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
Jerome L. Sandler		6490 Landover Rd, Landover Pk, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		JAN. 24, 1979		GATE OF HEAVEN CEM.	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
CHAMBERS FUNERAL HOME - RIVERDALE, MARYLAND				JAN 29 1979	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE	
				J. J. McCurdy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 79-04955

1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Ella M. Lee</b>			2a DATE OF DEATH MONTH DAY YEAR <b>February 19, 1979</b>		2b HOUR <b>2:30P.M.</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Oct 7, 1899</b>		
6 AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington D C</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9 BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b> MD.						
10 CITY OR TOWN OF DEATH <b>Riverdale</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Leland Memorial Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		
12b KIND OF BUSINESS OR INDUSTRY <b>Home</b>						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a STATE <b>Md</b>		13b COUNTY <b>Pro Georges</b>		13c CITY OR TOWN <b>Avondale</b>		
13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>2005 Woodreeve Road</b>				
14 FATHER'S NAME FIRST MIDDLE LAST <b>Milton Clark</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Daisy Brown</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b SOCIAL SECURITY NO. <b>578 01 5986</b>		17 INFORMANT ADDRESS <b>Virginia L Crawford Avondale, Md.</b>		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemic Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 h.</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Septicemia. Arteriosclerotic cv disease</b>						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from <b>11-18</b> , 19 <b>74</b> , to <b>2-4</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>2-4</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE <b>Ronald S. Fleischer</b>		DEGREE		22c DATE SIGNED <b>2-20-79</b>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>RONALD S. FLEISCHER, M.D.</b>		22e ADDRESS <b>7411 Riggs Rd. Hyattsville, Md.</b>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>Feb 23, 1979</b>		23c NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		
23d LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood Pro Georges Md.</b>						
24 FUNERAL DIRECTOR NAME ADDRESS <b>F. Gasch's Sons P A Hyattsville, Md.</b>		25a DATE REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE <b>Feb 23 1979</b>				

2/20/79 M/F notified and did approve CG

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified advance.



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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04956

1. FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>LILLIAN MARIE LEETH</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>02 20 79</b>			2b. HOUR <b>12:46P.M.</b>			
3 SEX <b>Female</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>09 18 1894</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>84</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES</b> MD.			
10 CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTHERN MARYLAND HOSPITAL CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired - homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a STATE <b>Md.</b>		13b COUNTY <b>Prince Georges</b>		13c CITY OR TOWN <b>Antallion</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		14 STREET ADDRESS <b>714 Tantalion Drive</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Randolph Robertson</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Florence Herbery</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b SOCIAL SECURITY NO. <b>213-54-7061</b>		17 INFORMANT ADDRESS <b>Mrs. Esther Turner 7409 Masters Dr. Potomac, Md.</b>					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Md.</b>
19a. DATE OF OPERATION <b>2/19</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>2/19</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>5620 St. Barnabas Rd. Oxon Hill, Maryland</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>2/19</b> , 19 <b>79</b> , to <b>2/20</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>2/20</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									22c. DATE SIGNED <b>2/21/79</b>
22b. SIGNATURE <i>G. H. Nachnani</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G. H. Nachnani</b>				22e. ADDRESS <b>5620 St. Barnabas Rd. Oxon Hill, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb. 23, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Maryland</b>			
24 FUNERAL DIRECTOR NAME <b>Hysong's Funeral Home</b>				ADDRESS <b>1300 N St. N.W. Wash. D.C.</b>		25. DATE REC'D BY REGISTRAR <b>FEB 27 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Shirley M. Cundy</i>	

1. FOR STATE REGISTRAR

2. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

3. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-04957	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNE KATHY MARIE LINDMAN						2a. DATE OF DEATH MONTH DAY YEAR FEB. 24, 1979			2b. HOUR 11:30 PM		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 - 04 - 13		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Dakota		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.					
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Social Services			12b. KIND OF BUSINESS OR INDUSTRY State of Md.		
13a. STATE Maryland						13b. COUNTY P.G.		13c. CITY OR TOWN Oxon Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Albert N. Johnson						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maltilda L. Ahlstrom					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 470-18-4691a		17. INFORMANT ADDRESS John G. Lindman (Husband) Same as item 13a					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Failure + Bleeding</u> 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic cancer of Colon and Liver</u> (c) <u>Liver</u> DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1-4-79</u> , 1979, to <u>1-16-79</u> , 1979, that (I) (we) last saw the deceased alive on <u>1-16-79</u> , 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE A. Shamim MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. SHAMIM						22e. ADDRESS 200 Ft. Meade Rd - Laurel, Md. 20610					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2-28-79		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln			23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland		
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill Maryland						25a. DATE REC'D. BY REGISTRAR MAR 01 1979			25b. REGISTRAR'S SIGNATURE P. Kelly McCreedy		

MEDICAL CERTIFICATION

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. <b>79-04958</b>	
1. DECEASED NAME (TYPE OR PRINT) <b>Alice Marie LINGENFELTER</b>										2a. DATE OF DEATH MONTH <b>2</b> DAY <b>7</b> YEAR <b>1979</b>										2b. HOUR <b>3:39</b> M	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>4</b> DAY <b>12</b> YEAR <b>1966</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>66</b> YRS.		IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>		7c. DATE PRONOUNCED DEAD <b>2-7-79</b>		2d. HOUR <b>3:39</b> M							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penn</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES</b> MD.									
10. CITY OR TOWN OF DEATH <b>Cheverley</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince George General Hosp</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>									
13a. STATE <b>Md</b>				13b. COUNTY <b>Prince George</b>				13c. CITY OR TOWN <b>Camp Springs</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS <b>6718 Botetourt Drive.</b>					
14. FATHER'S NAME FIRST <b>Robert</b> MIDDLE <b>Joseph</b> LAST <b>McClousey</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>Francers</b> LAST <b>Hofford</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>172-12-609d</b>				17. INFORMANT <b>Francers J Lingenfelter</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circumflex cordis vascular disease</b> <b>4392</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>				TITLE (SPECIFY) <b>DEPUTY</b>				MEDICAL EXAMINER <b>12800 WILLOW WIND CIRCLE</b>				DATE SIGNED <b>2-7-79</b>									
EXAMINER'S NAME (TYPE OR PRINT) <b>AUGUSTO P. RODRIGUEZ</b>				ADDRESS <b>OXON HILL, MD 20822</b>																	
23a. BURIAL, CREMATION, REMOVAL (PREPARE) <b>Burial</b>				23b. DATE <b>2/10/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Memorial Gardens</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Waldorf Potomac MD</b>											
24. FUNERAL DIRECTOR NAME <b>George P. Kabsch</b>				ADDRESS <b>6160 Oxon Hill Rd Hill Md</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 9 1979</b>				25b. REGISTRAR'S SIGNATURE <b>Kathy McCurdy</b>									

32240-28

32240-28



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 79-04959	
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Beadra Wilhemina Longerbeam</b>						2a. DATE OF DEATH KNOWN ESTIMATED <input checked="" type="checkbox"/> <b>2 12 1979</b>		2b. HOUR <b>2:25 P. M.</b>			
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 16, 61</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>17</b> YRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>2 12 1979</b>		7d. HOUR <b>P. M.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. Va.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Cheverly</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince George General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>School</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Pr. Geo's</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5627 Monroe Street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Howard Willis Longerbeam</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Potter</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>271 70 3099</b>		17. INFORMANT <b>Step Father</b> ADDRESS <b>Walter Grey Sr. same as above</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>Cranio-cerebral injuries</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>8147</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b) <b>8147</b> DUE TO, OR AS A CONSEQUENCE OF											
(c) <b>8147</b> DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR <b>1:42</b> PM MONTH <b>2</b> DAY <b>12</b> YEAR <b>1979</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>pedestrian struck by automobile</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>57th &amp; Rt. 202, Bladensburg PG County MD</b>					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Virginia L. Dolan</b> M.D.						TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER			DATE SIGNED <b>2/13/79</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>						ADDRESS <b>111 Penn Street, Balto., MD 21201</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>2/16/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood Pr. Geo's Md</b>		
24. FUNERAL DIRECTOR NAME <b>Francis Gasch's Sons, PA</b> ADDRESS <b>Hyattsville, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 15 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Patrick McCreedy</b>			

19-01022



Handwritten notes and stamps, including a large circular stamp on the left side and various illegible markings throughout the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-04960	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST THOMAS A. LOUGHREY						2a. DATE OF DEATH MONTH DAY YEAR 2 21 79		2b. HOUR 8:49A M			
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 2- 16-1900		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.					
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GEN HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Charter Agent-Wash. Coach Co.		12b. KIND OF BUSINESS OR INDUSTRY			
13a STATE Md.		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3611 Gramby St.			
14 FATHER'S NAME FIRST MIDDLE LAST A1 Loughrey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Corr		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 579-09-6932A		17 INFORMANT ADDRESS George Loughrey/ Same as # 13							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiac arrest; 0971 } DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic Heart disease; Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) Late Syphilis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 2/16, 19 79, to 2/20, 19 79, that (I) (we) last saw the deceased alive on 2/20, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Susan Lajda		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 2/21/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SUSAN LAJDA, MD		22e. ADDRESS 6201 greenbelt Rd., College Plk., Md									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-23-79		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.		23e. DATE REC'D. BY REGISTRAR FEB 26 1979			
24 FUNERAL DIRECTOR NAME Robert G. Beall Funeral Home 9013 Annapolis Rd. Lanham, Md.		25a. DATE REC'D. BY REGISTRAR FEB 26 1979									
25b. REGISTRAR'S SIGNATURE Rafael M. Brady											

75-04960

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED

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U.S.A.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 79-04961	
1. DECEASED NAME (TYPE OR PRINT) <b>Winnne MACKENZIE</b>										2a. DATE KNOWN OF DEATH ESTIMATED <b>2-7</b> 19 <b>79</b>	
1. SEX <b>Female</b> 4. RACE <b>White</b> 5. DATE OF BIRTH <b>11-11-27</b> 6. AGE (IN YEARS) <b>76</b> 7. IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										2c. DATE PRONOUNCED DEAD <b>2-7</b> 19 <b>79</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>England</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES</b>			MD.		
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Pr. Geo. Gen. Hosp.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		
13a. STATE <b>Md.</b>			13b. CITY OR TOWN <b>Pr. Geo.</b>			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>6011 - Emerson Street</b>		
14. FATHER'S NAME <b>Thomas</b>			15. MOTHER'S MAIDEN NAME <b>Rose</b>			16. SOCIAL SECURITY NO. <b>579-16-5490</b>			17. INFORMANT <b>Kenneth W. Mackenzie</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>579-16-5490</b>			17. INFORMANT <b>Kenneth W. Mackenzie</b>			17. INFORMANT <b>Fulton, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Atherosclerotic cardiovascular disease</b> IMMEDIATE CAUSE: <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4292</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>			TITLE (SPECIFY) <b>DEPUTY</b>			DATE SIGNED <b>2-8</b> 19 <b>79</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>AUGUSTO P. RODRIGUEZ</b>			M.D. <b>M.D.</b>			MEDICAL EXAMINER					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>2-12-79</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>		
24. FUNERAL DIRECTOR NAME <b>Nalley's F.H. Inc.</b>			ADDRESS <b>Mt. Rainier, Md.</b>			25. DATE REC'D. BY REGISTRAR <b>FEB 13 1979</b>			25. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

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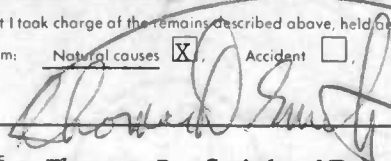
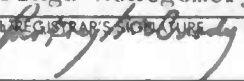
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										79-04962 REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>John Joseph Mallon</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1 30 19 79</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec 7, 1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>58 YRS.</b>		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>1 30 19 79</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Lanham</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Doctor's Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Construction Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Free State</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Md</b>		13b. COUNTY <b>Pro Georges</b>		13c. CITY OR TOWN <b>College Park</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>7323 Baylor ave</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Mallon</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Edna Hingler</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>139 24 2873</b>		17. INFORMANT ADDRESS <b>Dorothy M Mallon College Park, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE 				TITLE (SPECIFY) <b>Deputy Chief</b>				DATE SIGNED <b>1/31/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, MD.</b>				ADDRESS <b>111 Penn St. Balto., MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Feb 3, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Springs Montgomery Md</b>	
24. FUNERAL DIRECTOR NAME <b>F. Gasch's Sons P A Hyattsville, Md.</b>						25a. DATE REC'D. BY REG. CLERK <b>FEB 6 1979</b>		25b. REGISTRAR'S SIGNATURE 			



2-04885

*[Handwritten signature]*

1952 FEB 2

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **79-04963**

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 2 25 79										2b. HOUR 19 M	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		MILTON H. MARTIN					
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR		2d. HOUR	
Male	Black	2 26 18		61 YRS.						3 3 79		19 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		USA		Prince George's County MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Upper Marlboro		3912 Croom Station Rd.				Ret. Custodian			Schools				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
				Md.		Prince George		Upper Marlboro				3912 Croom Station Road	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
unk.				unk.									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
yes				unk.		412-16-1675 Detective Cielselski-P.G. Co. Police Dept.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Multiple stabwounds</b> IMMEDIATE CAUSE (a) <b>966-</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				? P.M. 3 19 79		stabbed by assailant							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE							
				Home		3912 Croom Station Upper Marlboro, Maryland							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Margarita A. Korell</i>				TITLE (SPECIFY) Assistant				DATE SIGNED 3/5/79					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS									
Margarita A. Korell, M.D.				111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN		COUNTY	STATE	
Cremation				3-15-79		Westview Mem. Park			Baltimore		Balt.	Md.	
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
ANATOMY BOARD OF MARYLAND				Baltimore, Md.				MAR 21 1979					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04964

1. DECEASED NAME (TYPE OR PRINT) <i>ROSE ANNE MASTIN</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>02-18-79</i>			2b. HOUR <i>11<sup>45</sup> AM</i>			
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>01 29 1888</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>91</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Ireland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George County MD.</i>			
10. CITY OR TOWN OF DEATH <i>SUITLAND</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>SUITLAND Nursing Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
13a. STATE <i>Md.</i>			13b. COUNTY <i>Prince George</i>		13c. CITY OR TOWN <i>Bladensburg</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>John J. NOONAN</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary CARABINE</i>			16. SOCIAL SECURITY NO. <i>578-30-8073A</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>578-30-8073A</i>			17. INFORMANT <i>2405 Whitehall Square SUITLAND Md. 20023</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular Disease</i> <i>4140</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Yellow</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>11-9</i> , 19 <i>74</i> , to <i>02-18</i> , 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>Feb 16</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>F. Joseph C. Fisher, M.D.</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>2-18-79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>2/22/1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Wash., D.C.</i>		
24. FUNERAL DIRECTOR NAME <i>Nalley's F.H. Inc.</i>			ADDRESS <i>Mt. Rainier, Md.</i>			25. DATE REC'D. BY REGISTRAR <i>FEB 26 1979</i>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. <b>79-04965</b>				
1. DECEASED NAME (TYPE OR PRINT)					FIRST <b>Lori</b>					MIDDLE <b>A.</b>					LAST <b>Maurer</b>					2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR		2b. HOUR <b>11</b> <b>19</b> <b>79</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>March</b> DAY <b>13</b> YEAR <b>59</b>			6. AGE (IN YEARS) LAST BIRTHDAY <b>19</b> YRS.		IF UNDER 1 YR. MONTHS <b>XX</b> DAYS <b>XX</b>		IF UNDER 24 HRS. HOURS <b>2</b> MIN. <b>11</b>		2c. DATE PRONOUNCED DEAD <b>2</b> <b>12</b> <b>19</b> <b>79</b>		2d. HOUR <b>4:44A</b>									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>					7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County, MD</b>									
10. CITY OR TOWN OF DEATH <b>Cheverly</b>					11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince George's General Hospital</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>					12b. KIND OF BUSINESS OR INDUSTRY <b>none</b>									
13a. STATE <b>Maryland</b>					13b. COUNTY <b>Pr. Geo's</b>					13c. CITY OR TOWN <b>Riverdale</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS <b>6813 Riverdale Rd.</b>				
14. FATHER'S NAME FIRST <b>William H.</b> MIDDLE <b>Maurer</b> LAST <b>Cleo</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Cleo</b> MIDDLE <b>Powers</b> LAST <b>Powers</b>					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>					16b. SOCIAL SECURITY NO. <b>218-66-7455</b>					17. INFORMANT ADDRESS <b>Genevieve Sexton(aunt) Cheverly, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4280</b> IMMEDIATE CAUSE (a) <b>Congestive heart failure</b>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
DUE TO, OR AS A CONSEQUENCE OF																								
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																								
DUE TO, OR AS A CONSEQUENCE OF																								
DUE TO, OR AS A CONSEQUENCE OF																								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE														
22a. I certify that I took charge of the remains described above, held on <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																								
ACTUAL SIGNATURE <i>Thomas D. Smith</i>					TITLE (SPECIFY) <b>Deputy Chief</b>										DATE SIGNED <b>2/12/79</b>									
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>					ADDRESS <b>111 Penn St. Balto., MD.</b>																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>					23b. DATE <b>2/15/79</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>					23d. LOCATION CITY OR TOWN <b>Washington, D. C.</b> COUNTY STATE									
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons, PA, Hyattsville, Md.</b>										25a. DATE REC'D. BY REGISTRAR <b>FEB 15 1979</b>					25b. REGISTRAR'S SIGNATURE <i>P. J. McCreedy</i>									



78-04382

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(1) 11-11-11

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 79-04966			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Paul Clayton MAXWELL, Sr..										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 2-18 19 79		2b. HOUR M P:45	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 8-24-04		6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN 74 YRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2-18 19 79		7d. HOUR M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D. C.			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.				
10. CITY OR TOWN OF DEATH CHEVERLY			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PR, GEORGES GEN, HOSP.(DOA)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRINTER			12b. KIND OF BUSINESS OR INDUSTRY WASH. POST			
13a. STATE MARYLAND			13b. COUNTY PR. GEORGES		13c. CITY OR TOWN MARLOW HTS.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2900 ST. CLAIRE DRIVE, APT 201				
14. FATHER'S NAME FIRST MIDDLE LAST RAY WORTH MAXWELL					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNE UNKNOWN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) IF YES, GIVE WAR OR DATES NO				16b. SOCIAL SECURITY NO. 577-03-2698		17. INFORMANT SON			ADDRESS 917 RUNNYMEADE DR FREDERICK, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 CHRONIC OBSTRUCTIVE PULMONARY DISEASE													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Augusto P. Rodriguez				TITLE (SPECIFY) DEPUTY				DATE SIGNED 2-20-79					
EXAMINER'S NAME (TYPE OR PRINT) AUGUSTO P. RODRIGUEZ M.D.				ADDRESS 12800 WILLOW WIND CIRCLE, TANTALLON, MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 2/22/79		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN			23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.					
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS						25a. DATE REC'D. BY REGISTRAR FEB 22 1979		25b. REGISTRAR'S SIGNATURE Dorothy McLeod					
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901													

33610-05

95/22/9

101503

FRANCIS J. COLLINS

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 79-04967	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) <i>Charles William McClelland</i>			2a. DATE KNOWN OF DEATH ESTIMATED <i>2-14</i> 19 <i>79</i>			2b. HOUR		
3. SEX <i>Male</i>			4. RACE <i>White</i>		5. DATE OF BIRTH MONTH <i>1</i> DAY <i>25</i> YEAR <i>18</i>		6. AGE (IN YEARS) LAST BIRTHDAY <i>61</i> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>PRINCE GEORGES</i> MD.		
10. CITY OR TOWN OF DEATH <i>Adelphi</i>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>9282-Adelphi Road</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired-Tour Guide</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Gray Lines C</i>	
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Prince George</i>		13c. CITY OR TOWN <i>Adelphi</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>9282-Adelphi Road</i>		
14. FATHER'S NAME FIRST <i>William</i> MIDDLE <i>Powell</i> LAST <i>McClelland</i>			15. MOTHER'S MAIDEN NAME FIRST <i>Sara</i> MIDDLE <i>Anna</i> LAST <i>Higgs</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Yes-U.S.A.</i> (IF YES, GIVE WAR OR DATES) <i>WWII</i>			16b. SOCIAL SECURITY NO. <i>579-07-2135</i>		
17. INFORMANT <i>Billie D. McClelland-Wife</i>			ADDRESS <i>Same as #13</i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i> <i>4292</i> Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>			TITLE (SPECIFY) M.D. <i>DEPUTY</i> MEDICAL EXAMINER			DATE SIGNED <i>2-14-80</i>					
EXAMINER'S NAME (TYPE OR PRINT) <i>AUGUSTO P. RODRIGUEZ M. D</i>			ADDRESS <i>12800 WILLOW WIND CIRCLE, TANTALLON, MD</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>			23b. DATE <i>Feb. 17, 1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lee's Crematory</i>			23d. LOCATION CITY OR TOWN <i>Washington, D.C.</i> COUNTY <i>20022</i> STATE			
24. FUNERAL DIRECTOR NAME <i>J.W.M. Lee's Sons Co.</i> ADDRESS <i>300-4th St., NE, Wash., D.C.</i>						25a. DATE REC'D. BY REGISTRAR <i>FEB 21 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Robert McCready</i>			

73002

73040-05

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-04968		
FOR 1. STATE REGISTRAR					REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) <b>LUCY E. McDERMOTT</b>					2a. DATE OF DEATH MONTH <b>2</b> DAY <b>20</b> YEAR <b>79</b>					2b. HOUR <b>11:45 PM</b>		
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH <b>11</b> DAY <b>6</b> YEAR <b>1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70 yrs.</b>			IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash., DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Pr. Geo.</b>					MD.	
10. CITY OR TOWN OF DEATH <b>College Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8405- 48th Ave.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>8405- 48th Ave.</b>				
13a. STATE <b>Md.</b>		13b. COUNTY <b>Pr. Geo.</b>		13c. CITY OR TOWN <b>College Park</b>								
14. FATHER'S NAME FIRST <b>Benjamin</b> MIDDLE <b>Mortimer</b> LAST <b>Mortimer</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Madeleine</b> MIDDLE <b>Rohmer</b> LAST <b>Rohmer</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>579-28-9645</b>		17. INFORMANT ADDRESS <b>Michael J. McDermott- above address</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA OF LIVER</b> <b>1539</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMA OF COLON</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>2 yrs.</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 yrs.</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>4-19-79</b> 19 <b>79</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>2-19-79</b> 19 <b>79</b> , to <b>2-20-79</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>2-19-79</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Ronald S. Fleischer</b>					DEGREE <b>2</b>			22c. DATE SIGNED <b>2-21-79</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RONALD S. FLEISCHER M.D.</b>					22e. ADDRESS <b>7411 RIGGS RD. HYATTSVILLE, MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>2/24/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Brentwood</b> COUNTY <b>Pr. Geo.</b> STATE <b>Md.</b>				
24. FUNERAL DIRECTOR NAME <b>Nalley's F.H. Inc.</b>			ADDRESS <b>Mt. Rainier, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>FEB 27 1979</b>			25b. REGISTRAR'S SIGNATURE <b>Anthony McBrady</b>			



88240-25

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific information required.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at page 3.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-04969		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
Male / Baby.					McInerney.	2/3/79						5:30 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male				MONTH DAY YEAR 2 3 79				MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
MARYLAND		U.S.				MD.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
			PRINCE GEORGE'S HOSP.									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		YES <input type="checkbox"/> NO <input type="checkbox"/>						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST			FIRST MIDDLE LAST									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7651 PREMATURE DUE TO, OR AS A CONSEQUENCE OF (b) (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
MEDICAL CERTIFICATION												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE D. Chellappa MD						DEGREE		22c. DATE SIGNED 2/3/79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID CHELLAPPA MD						22e. ADDRESS PRINCE GEORGE'S GEN HOSP.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation			23b. DATE 3/7/79		23c. NAME OF CEMETERY OR CREMATORY Prince George's Hospital		23d. LOCATION CITY OR TOWN Cheverly, P.G. County, Md.					
24. FUNERAL DIRECTOR NAME Raleigh Cline, Cheverly, Maryland			25a. DATE REC'D. BY REGISTRAR MAR 13 1979		25b. REGISTRAR'S SIGNATURE [Signature]							

93810-81

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-04970				
1. FOR STATE REGISTRAR										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>ELIZABETH C. MCKEE</b>					2a. DATE OF DEATH		MONTH <b>2</b>		DAY <b>4</b>		YEAR <b>79</b>		2b. HOUR <b>9:10</b> P.M.	
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH <b>Mar.</b> DAY <b>9,</b> YEAR <b>1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Pr. Geo.</b> MD.								
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll Manor Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>V.A.</b>						
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Wheaton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3603 May Street</b>						
14. FATHER'S NAME FIRST <b>James</b> MIDDLE <b></b> LAST <b>Ward</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Katherine</b> MIDDLE <b></b> LAST <b>Greely</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>577-60-3507</b>		17. INFORMANT <b>son</b>		ADDRESS <b>same as 13</b>								
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>4340</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cerebrovascular Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b> <b>3 wks.</b>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b></b> P.M. <b></b> <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b></b>		CITY OR TOWN <b></b>		COUNTY <b></b> STATE <b></b>				
22a. I certify that (1) (the deceased) attended the deceased from <b>Jan 13</b> , 19 <b>79</b> , to <b>Feb 4</b> , 19 <b>79</b> , that (1) (the) last saw the deceased alive on <b>Feb 4</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (do) (did not) view the body after death.														
22b. SIGNATURE <b>James J. Foster M.D.</b>								DEGREE <b></b>		22c. DATE SIGNED <b>2/4/79</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES J. FOSTER M.D.</b>								22e. ADDRESS <b>916 19th N.W.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb. 8, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>				23d. LOCATION CITY OR TOWN <b>Silver Spring Mont.</b> COUNTY <b></b> STATE <b>Md.</b>						
24. FUNERAL DIRECTOR'S NAME <b>Francis J. Collins</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 5 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Lifsey McCreedy</b>						
500 University Blvd., W. Silver Spring, Md.														

3402 BP

79-01210

1-1-79

James  
237-44-3207  
John J. Miller  
Katherine  
and  
George  
3612 NW 20th St  
Miami, FL 33155  
U.S.A.  
P.O. Box  
Washington, D.C. 20540  
White  
June 8, 1992  
88

500 University Road, W. St. John's, A.B. 1A1 3X9  
Francis J. Collins  
Feb. 1, 1992  
Office of Human  
Genetics Research, NIH  
Silver Spring, Md. 20910

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-04971

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Carolyn A. McLaughlin</i>						2a. DATE KNOWN OF DEATH ESTIMATED <i>2-24 1979</i>			2b. HOUR M <i>6:15</i> M <i>6:15</i>		
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH <i>2</i> DAY <i>28</i> YEAR <i>45</i>	6. AGE (IN YEARS) (LAST BIRTHDAY) <i>33</i> YRS.	IF UNDER 1 YR. MONTHS <i>0</i> DAYS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i> MIN. <i>0</i>	7c. DATE PRONOUNCED DEAD <i>2-24 1979</i>			7d. HOUR M <i>6:15</i> M <i>6:15</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>WASH. D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD					
10. CITY OR TOWN OF DEATH <i>Chesley</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prince Georges Gen. Hosp. (DCA)</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>—</i>			
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>Maryland</i> COUNTY <i>Prince Georges</i> CITY OR TOWN <i>Oral Hills</i>				13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS <i>4305 Southern Avenue</i>					
14. FATHER'S NAME FIRST <i>JAMES</i> MIDDLE <i>M</i> LAST <i>MILLS</i>				15. MOTHER'S MAIDEN NAME FIRST <i>LENA</i> MIDDLE <i>Mc GILVER</i> LAST <i>Mc GILVER</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>				16b. SOCIAL SECURITY NO. <i>577624857</i>		17. INFORMANT ADDRESS <i>Thomas McLaughlin HUSBAND SAME 13</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Conductionopathy</i> <i>4254</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <i>Emmacration, Hepatic cirrhosis</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) <i>Deputy</i> MEDICAL EXAMINER				DATE SIGNED <i>2/25/79</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez</i>				ADDRESS <i>12800 Willow Wind Circle, Oxon Hill, Md. 20022</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Byrini</i>		23b. DATE <i>2-28-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>CEAR Hill Cem.</i>				23d. LOCATION CITY OR TOWN <i>Suitland</i> COUNTY <i>D.C.</i> STATE <i>Md.</i>			
24. FUNERAL DIRECTOR NAME <i>John F. Delaf</i> ADDRESS <i>DEVOI Funeral Home WASH. D.C.</i>				25a. DATE REC'D. BY REGISTRAR <i>MAR 2 1979</i>				25b. REGISTRAR'S SIGNATURE <i>History McCreedy</i>			

19-01971

CHIEF

M. E. NOTIFIED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of age.

BP

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04972

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
DECEASED NAME (TYPE OR PRINT)		ELIZABETH M MC MANUS		02	13	79	12:30 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female	Caucasian	MONTH DAY YEAR 3 26 1971	67	MONTHS	DAYS	HOURS	MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				
Penna.	U.S.A.		PRINCE GEORGES MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
CHEVERLY	PRINCE GEORGES GENERAL HOSPITAL		Housewife		-		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS		
Md.	Pr. Geo.	Cottage City	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	4142-Bunker Hill Rd.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		ADDRESS			
FIRST MIDDLE LAST Benjamin T. Drass		FIRST MIDDLE LAST Mary Schilling					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
No		213-80-7543		James E. McManus - above address (husband)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:							28 hrs.
IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA							
4149 DUE TO, OR AS A CONSEQUENCE OF (b) CORDNARY ARTERY DISEASE							2 yr
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSION							2 yr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2. 12. 19 79, to 2. 13. 19 79, that (I) (we) last saw the deceased alive on 2. 13. 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
VP Singh		M.D.		2. 14. 79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
VIRENDER P. SINGH		3700 East W. Highway #100 HYATTSVILLE MD 20782					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		2/16/1979		Gate of Heaven Cem.		Silver Spring Mont. Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Malley's F.H. Inc.		Mt. Rainier, Md.		FEB 21 1979		Pinky McCready	



19-04875

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04973

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jeannette H. Meade			2a. DATE OF DEATH MONTH DAY YEAR 2/16/79		2b. HOUR 1:05 PM	
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR June 12 1889		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.			10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) None	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY None			
13a. STATE Md.			13b. COUNTY Pr. Geo. Co		13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME FIRST MIDDLE LAST Isaac Hailey			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT ADDRESS Mrs. Elizabeth Proctor Same as 13c		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Negation of Stroke with Abnormal Metabolism</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (I) (this hospital) attended the deceased from <u>August 6, 1977</u> to <u>Feb 16, 1979</u> , that (I) (we) last saw the deceased alive on <u>Feb. 27, 1979</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22a. SIGNATURE <u>Howard W. Kenney</u>		DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>Feb 19 '79</u>		22b. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Howard W. Kenney, M.D.</u>		22e. ADDRESS <u>111 Spring St., Silver Spring, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 22 1979		23c. NAME OF CEMETERY OR CREMATORY Roselawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Richmond, Virginia
24. FUNERAL DIRECTOR NAME John T. Rhines Co. Funeral Home				25a. DATE RECD. BY REGISTRAR FEB 26 1979		
ADDRESS 3015 12th St N.E.D. C.				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

19-04813

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 79-04974			
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JAMES CARROLL MIDDLETON</b>								2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR <b>2 28 19 79</b>		2b. HOUR AM PM <b>11 31 A</b>	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 18, 1941</b>		6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>37</b>		IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>		IF UNDER 24 HRS. HOURS MIN. <b>00 00</b>		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>3 1 19 79</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County</b>	
10. CITY OR TOWN OF DEATH <b>Cheverly</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince George's Co. Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mechanic</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Auto</b>	
13a. STATE <b>Md.</b>				13b. COUNTY <b>Prince Geos.</b>				13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS <b>5904 63rd Ave.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eva Virginia ?</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>230 53 7076</b>				17. INFORMANT ADDRESS <b>Oscar James- (same as decedent)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Hanging</b> IMMEDIATE CAUSE (a) <b>9530</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION <b>between 2/28/79 and 3/1/79</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>hanged self</b>						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>8:50 P.M. 3/1/79</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>hanged self</b>									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>auto shop</b>				21i. LOCATION STREET CITY OR TOWN COUNTY STATE <b>5904 63rd Riverdale Prince George, Maryland</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <b>Margie DeWille</b>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>3/5/79</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn Street</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>3/10/79</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Marylandover, Md</b>	
24. FUNERAL DIRECTOR NAME <b>Robert G. Mason, Inc.,</b>				ADDRESS <b>Washington, D.C.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 13 1979</b>				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

10-0421

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M/7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										79-04975	
1- STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <i>Marie E. MIHM</i>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 2-11-79		2b. HOUR M			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1-15-91</i>		6. AGE (IN YEARS) LAST (BIRTHDAY) MONTHS DAYS HOURS MIN <i>88</i> YRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>2-11-79</i>		7d. HOUR M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Mass.</i>				7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD.			
10. CITY OR TOWN OF DEATH <i>Hyattsville</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, CITY, GIVE STREET ADDRESS) <i>Carroll Manor Nursing Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <i>DC</i>		13b. COUNTY		13c. CITY OR TOWN <i>Washington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>4201 Mass. Ave. NW</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>William n/a Murphy</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Margaret E. Delaney</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>578-10-1445 D</i>		17. INFORMANT ADDRESS <i>Joseph C. Mihm 2449 Shenandoah, Vienna, Va</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I-DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiac vascular disease</i> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2- OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>Diabetes mellitus, Fracture right hip, osteoporosis, Arthritis Fx 11th</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) <i>Deputy</i> M.D.				DATE SIGNED <i>2-11-79</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez</i>				ADDRESS <i>12800 Willow Wind Circle, Oxon Hill, Md. 20022</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		23b. DATE <i>2/14/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Washington, D.C.</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>Murphy F.H. 4510 Wilson Blvd. Arlington, Va.</i>						25a. DATE REC'D BY REGISTRAR <i>FEB 15 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Anthony McHenry</i>			

10-04012

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-04976	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) GERALDINE MINNIS					2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 15 1979					2b. HOUR 0930AM	
3. SEX FEMALE		4. RACE NEGROID		5. DATE OF BIRTH MONTH DAY YEAR MAY 28 1932		6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.					
10. CITY OR TOWN OF DEATH ANDREWS AIR FORCE BASE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MALCOLM GROW USAF MEDICAL CTR				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WAITRESS			12b. KIND OF BUSINESS OR INDUSTRY RESTURANT		
13a. STATE MARYLAND		13b. COUNTY PRINCE GEORGES		13c. CITY OR TOWN ANDREWS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5141 JERSTAD CT, ANDREWS AFB MD			
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM MCCRAY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARRIE BELLE									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 240-38-451B		17. INFORMANT WILLIAM MINNIS/HUS 5141B JERSTAD COURT, ANDREWS AFB, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> 5715 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Gastrointestinal Hemorrhage</u> (c) <u>Hepatic Cirrhosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Blazon</u> MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 15 FEB 79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN C LARZARUS, MAJ, USAF, MD				22e. ADDRESS ANDREWS AFB, MARYLAND 20331 MALCOLM GROW USAF MEDICAL CENTER							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 2/17/79		23c. NAME OF CEMETERY OR CREMATORY Scarborough Funeral Home				23d. LOCATION CITY OR TOWN COUNTY STATE Durham, North Carolina			
24. FUNERAL DIRECTOR NAME ADDRESS Alexander S. Pope, 2617 Pennsylvania Ave., S.E.				25a. DATE REC'D. BY REGISTRAR FEB 22 1979		25b. REGISTRAR'S SIGNATURE <u>Barney McCurdy</u>					

MEDICAL CERTIFICATION

1102 BP

0740-28

26

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										79-04977 REG. NO.																																							
1. DECEASED NAME (TYPE OR PRINT) <i>Elizabeth M. Monahan</i>							2a. DATE KNOWN OF DEATH ESTIMATED <i>2-26 1979</i>		2b. HOUR <i>PM</i>																																								
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>7-25-94</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>84</i> YRS.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD <i>2-26 1979</i>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore</i>		2d. HOUR <i>PM</i>																																									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore</i>		MD.																																									
10. CITY OR TOWN OF DEATH <i>Cheverly</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prince Georges General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>																																									
13a. STATE <i>Maryland</i>										13b. COUNTY <i>Ann Arundel</i>										13c. CITY OR TOWN <i>Annapolis</i>										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS <i>445 Waggaman Circle, 21403</i>									
14. FATHER'S NAME <i>Philip W. Marhoefer</i>										15. MOTHER'S MAIDEN NAME <i>Marie Gebhard</i>																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>										16b. SOCIAL SECURITY NO. <i>577-86-0420</i>										17. INFORMANT ADDRESS <i>Mrs. Albert L. Schiavone-Same as items 13</i>																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple injuries</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>8129</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (c) <i>8129</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																																																	
19a. DATE OF OPERATION <i>2/26-79</i>										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>Exploratory laparotomy</i>										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																													
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>2-26 1979</i>										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Motorist collision</i>																													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Street</i>										21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>Route 50, Cheverly, Prince Georges, Md</i>																													
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																																																	
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>										M.D. <i>Deputy</i> MEDICAL EXAMINER										DATE SIGNED <i>2-28-79</i>																													
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez</i>										ADDRESS <i>12800 Willow Wind Circle, Tenk...</i>																																							
23a. BURIAL, CREMATION, REMOVAL (SCIFI) <i>Burial</i>										23b. DATE <i>3/12/79</i>										23c. NAME OF CEMETERY OR CREMATORY <i>Albany Rural</i>										23d. LOCATION CITY OR TOWN COUNTY STATE <i>Colonie, Albany Co., New York</i>																			
24. FUNERAL DIRECTOR NAME <i>W. W. Chambers Co.,</i>										ADDRESS <i>Riverdale, Maryland</i>										25a. DATE REC'D. BY REGISTRAR <i>MAR 5 1979</i>										25b. REGISTRAR'S SIGNATURE <i>Robert McHenry</i>																			

10-0417

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 79-04978					
1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Rayner A MONTGOMERY, Sr.				2a. DATE OF DEATH MONTH DAY YEAR February 28, 1979				2b. HOUR 5:45 a.m.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6-28-1903		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.					
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors Hosp. of P. G. County				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Shipping Clerk			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Brentwood		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3802 - Cedar Croft Pl.			
14. FATHER'S NAME FIRST MIDDLE LAST Alexander Montgomery				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian O'Brian							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT Louise A. Montgomery		ADDRESS same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hr.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from <u>28 Feb.</u> 19 <u>79</u> to <u>28 Feb.</u> 19 <u>79</u> , that (1) (we) lost saw the deceased alive on <u>28 Feb.</u> 19 <u>79</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.											
22b. SIGNATURE <u>William A. Wimsatt</u> MD				DEGREE MD				22c. DATE SIGNED 28 Feb. 79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William A. Wimsatt, M.D.				22e. ADDRESS 8150 Lakecrest Dr., Greenbelt, Md. 20770							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-2-79		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.					
24. FUNERAL DIRECTOR NAME Nailey's F.H. Inc.				ADDRESS Mt. Rainier, Md.		25. DATE REC'D. BY REGISTRAR MAR 5 1979		25b. REGISTRAR'S SIGNATURE <u>Anthony McCready</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO. 79-04979	
1. DECEASED NAME (TYPE OR PRINT) <b>MOORE, DENICE VIOHA</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2/3/79</b>		2b. HOUR <b>12<sup>45</sup>/A</b> M
3. SEX <b>FEMALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>09 27 10</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's Co.</b> MD.		
10. CITY OR TOWN OF DEATH <b>Clinton</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Md. Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md.</b>		13b. COUNTY <b>Prince Geg.</b>	13c. CITY OR TOWN <b>Brandywine</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry Whitening</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ethel Sewell</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-74-6545</b>		17. INFORMANT ADDRESS <b>7604 Moores Rd</b> <b>Sidney A Moore, Sr. (Husband) Brandywine, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause, but list all contributing causes.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary artery occlusion</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Focal Subintimal hemorrhage into left coronary artery</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1-27</b> 19 <b>79</b> , to <b>2-2</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>2-1</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Rafael C. Lee, MD</b>		DEGREE		22c. DATE SIGNED <b>2-2 79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RAFAEL C LEE</b>		22e. ADDRESS <b>9410 Brandywine Rd Clinton Md</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2-5-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Asbury United Meth Ch. Cemetery</b>	
24. FUNERAL DIRECTOR NAME <b>Rollins Funeral Home, Inc.</b>		ADDRESS <b>4339 Hunt Pl., Washington, D.C.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 8 1979</b>	
				25b. REGISTRAR'S SIGNATURE <b>Anthony Delaney</b>	



10-01212

10-01212

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 12 hours after death.

# DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

79-04980

1. DECEASED-NAME (Type or print) <b>Wilson E. Moran</b>			2a. DATE OF DEATH Month <b>February</b> Day <b>1</b> Year <b>1979</b>		2b. HOUR <b>2:30</b> M.
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Oct. 12, 1922</b>		6. AGE (In years lost birthday) <b>56</b> YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince George's</b> Md.		
10. CITY OR TOWN OF DEATH <b>Cheverly</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo's General Hospital</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Assist. Power Plant Governmnt.</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government.</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Pr. Geo's</b>	13c. CITY OR TOWN <b>Upper Marlboro</b>	13d. INSURENCE LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>6409 Dower House Road</b>	
14. FATHER'S NAME First <b>Joseph</b> Middle <b>Henry</b> Last <b>Moran</b>	15. MOTHER'S MAIDEN NAME First <b>Mabel</b> Middle <b>--</b> Last <b>Norfolk</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes.</b>	(If yes give war or dates of service) <b>WWII</b>	16b. SOCIAL SECURITY NO.	17. INFORMANT <b>Ethel Moran-6409 Dower House Road Upper Marlboro, Md. 20870</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ischemic Brain damage.</b> <b>585-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardio-pulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hyper Kalaemia - volume overload</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e) <b>Chronic Renal failure</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>1-27, 1979</b> , to <b>2-1, 1979</b> , that (I) (we) last saw the deceased alive on <b>1-31, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Rishpal Singh</b>		DEGREE <b>M.D.</b>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>2/1/79:</b>	
22d. PHYSICIAN'S NAME (Type) <b>Rishpal Singh, M.D.</b>		22e. ADDRESS <b>4700 Auth Place Camp Springs, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2/3/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Bladensburg (Pr. Geo's) Md.</b>		
24. FUNERAL DIRECTOR <b>Richard A. Coleman-Upper Marlboro, Maryland 20870:</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 6 1979</b>	25b. REGISTRAR'S SIGNATURE <b>Rishpal Singh</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-04981	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
FIRST MIDDLE LAST <b>AGNES V. MOSES</b>					MONTH DAY YEAR <b>2 22 79</b>					12:40A	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		WHITE		MONTH DAY YEAR <b>JAN. 21, 1893</b>		86 YRS.		MONTHS DAYS		HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		U.S.A.				PRINCE GEORGE'S MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
RIVERDALE		LELAND MEMORIAL HOSPITAL				HOUSEWIFE		HOME			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
13a. STATE 13b. COUNTY 13c. CITY OR TOWN <b>MARYLAND PRINCE GEO. HYATTSVILLE</b>					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>4410 OGLETHORPE STREET-APT. 116</b>				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST <b>JOHN D. WARNICK</b>					FIRST MIDDLE LAST <b>AGNES - WILLIAMSON</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
NO --					215-20-7283		ANA A. ZOOK - ADDRESS SAME AS #13 ABOVE.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic shock with asystole</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>days</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>2/21</u> , 19 <u>79</u> , to <u>2/21</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>2/21</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<u>Byrd O. Johnson</u>				MD						2/22/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL				FEB. 26, 1979		LAUREL HILL CEMETERY		MOSCOW-ALLEGHENY-MARYLAND			
24. FUNERAL DIRECTOR NAME						ADDRESS		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			
CHAMBERS FUNERAL HOME - RIVERDALE, MARYLAND								FEB 26 1979 <u>Anthony McCreedy</u>			

18840-25

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-04982

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>HOMER COYLE MOUNTAIN</b>		2a DATE OF DEATH MONTH DAY YEAR <b>02 14 79</b>		2b HOUR <b>8:08P.M.</b>	
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>05<sup>TH</sup> 24<sup>Y</sup> 08<sup>EAR</sup></b>	
6 AGE (IN YEARS (LAST BIRTHDAY)) <b>70</b>		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b>			
10 CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTHERN MARYLAND HOSPITAL CENTER</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired - U. S. Gov't.</b>	
12b KIND OF BUSINESS OR INDUSTRY					
13a STATE <b>Md.</b>		13b COUNTY <b>Prince Georges</b>		13c CITY OR TOWN <b>Hillcrest Hts</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>William Mountain</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sadie Bennett</b>			
16a WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>578-20-5652</b>		17 INFORMANT ADDRESS <b>Ruth O. Mountain, Wife, Same as Above</b>	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Respiratory Arrest</b> <b>1551</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>Sepsis Shock</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cholangio Carcinoma</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs.</b> <b>4 hrs.</b> <b>3 months</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE <b>14 E 65 99</b>	
22a I certify that (1) (this hospital) attended the deceased from <b>14 Feb</b> 19 <b>79</b> , to <b>14 Feb</b> 19 <b>79</b> , that (1) (we) lost saw the deceased alive on <b>14 Feb</b> 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)					
22b SIGNATURE <b>James Levy</b>		DEGREE <b>M.D.</b>		22c DATE SIGNED <b>15 Feb 79</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>James Levy, M.D.</b>		22e ADDRESS <b>7801 Old Branch Ave. Clinton, Md. 20735</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>2-17-79</b>		23c NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>	
23d LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, P.G., Maryland</b>		23e DATE RECEIVED BY REGISTRAR <b>FEB 20 1979</b>			
24 FUNERAL DIRECTOR NAME <b>Robt E Wilhelm</b>		24b ADDRESS <b>4308 Suitland Rd., Suitland, Md.</b>			
24c FUNERAL HOME <b>Funeral Home</b>		24d REGISTRAR'S SIGNATURE <b>[Signature]</b>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

58010-07

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

58010-07

Order of the  
Secretary of Agriculture  
dated 10/1/1910

1. To the Director of the  
Bureau of Plant Industry

10-1-1910



**NOT TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES.

**NOT TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Info. added per phone call

STATE OF MARYLAND

1- FOR STATE REGISTRAR w/Anatomy Bd. 3/22/2018 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
Items #18a-22a MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-04983

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH		ESTI- MATED		MONTH		DAY		YEAR		2b. HOUR			
Vincent						Nichols		2		25		19		79							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR			
male		black		Jan. 20, 1979		YRS.		MONTHS		DAYS		HOURS		MIN.		2		25			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH													
Washington, D.C.		U.S.A.		WIDOWED		DIVORCED		Prince George County													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
Cheverly		Prince George's Hospital																			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
D.C.				Washington		YES		11 "R" St., N. W.													
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																			
FIRST		LAST		FIRST		LAST															
Venson		Prescott		Betty		Nichols															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS															
(IF YES, GIVE WAR OR DATES)		-																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden infant death syndrome 7980 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION																		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE				Margarita A. Korell				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER				DATE SIGNED 2/26/79					
EXAMINER'S NAME (TYPE OR PRINT)				Margarita A. Korell, M.D.				ADDRESS				111 Penn Street, Balto, MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN				COUNTY STATE					
Removal				3/15/79																	
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
Anatomy Board				Balto., Md.				MAR 27 1979				J. J. McCreedy									

88240-24

4  
Certified by Medical Examiner - Dr. Montgomery  
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 50M 7/77  
(VRA 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 14 57529 5/57/79 83		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		79-04984	
1- FOR STATE REGISTRAR		REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LAURA ELIZABETH NIELSEN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>FEB. 12, 1979</b>		2b. HOUR <b>11:19 AM</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>OCT. 15, 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MASS.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S</b> MD.	
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGE'S GENERAL HOSP.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>PRINCE GEO.</b>	13c. CITY OR TOWN <b>COLLEGE PARK</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Davis Belcher</b> <b>ARTHUR H. NIELSEN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>KATHERINE O. BORDEN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>220-46-8339</b>		17. INFORMANT ADDRESS <b>KATHERINE CLARK - ADDRESS SAME AS #13 ABOVE.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma of Breast</b> <b>1749</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/24</b> , 19 <b>78</b> , to <b>2/12</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>Jan</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <b>Dr. Leonard Gold MD</b>		DEGREE		22c. DATE SIGNED <b>FEB 13 1979</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Leonard Gold MD</b>		22e. ADDRESS <b>8630 Penton St Silver Spring Md 20910</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>FEB. 13, 1979</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CREMATORY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SUITLAND - P.G. - MD.</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>CHAMBERS FUNERAL HOME-RIVERDALE, MARYLAND</b>		25a. DATE REC'D BY REGISTRAR <b>FEB 13 1979</b>			
		25b. REGISTRAR'S SIGNATURE <b>Ready</b>			

48040-25

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		79-04985						REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Fannie J. Odum</b>						2a. DATE OF DEATH MONTH <b>2</b> DAY <b>9</b> YEAR <b>79</b>		2b. HOUR <b>2:40 P.M.</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>MAY</b> DAY <b>23</b> YEAR <b>1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES</b> MD.			
10. CITY OR TOWN OF DEATH <b>HYATTSVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MANOR CARE NURSING HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD.</b>		13b. COUNTY <b>PR. GEO.</b>		13c. CITY OR TOWN <b>HYATTSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2600 QUEENS CHAPEL RD</b>	
14. FATHER'S NAME FIRST <b>ROBERT</b> MIDDLE <b>S.</b> LAST <b>JONES</b>				15. MOTHER'S MAIDEN NAME FIRST <b>MARTHA</b> MIDDLE <b></b> LAST <b>TEMPLER</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>578 54 1976</b>		17. INFORMANT ADDRESS <b>BEATRICE V. DEY, 2600 QUEENS CHAPEL RD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>5188</b> IMMEDIATE CAUSE (a) <b>Acute Bronchial pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Lung Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4 yrs</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>9/28</b> , 19 <b>78</b> , to <b>2/9</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>2/8</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (He/she) (did not) view the body after death.									
22b. SIGNATURE <b>Myron R. Renteria</b>				DEGREE <b>ATTENDING PHYSICIAN</b>		MEDICAL <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2-9-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb. 13, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Seatonsville, Pr. Geo.</b> COUNTY <b>MD.</b> STATE <b>MD.</b>			
24. FUNERAL DIRECTOR NAME <b>Stewart W. Winters</b>		25a. DATE REC'D. BY REGISTRAR <b>254 Carroll St. N.W. Washington D.C. 20002</b>		25b. REGISTRAR'S SIGNATURE <b>FEB 13 1979</b>					

10-01992

10-01992



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO. 79-04986	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR	
Anne E. Owens				Feb. 5, 1979 1:45 PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	
Female		WHITE		18-16-99	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS.	
Washington, D.C.		U.S.A.		XXII 79 YRS MONTHS DAYS HOURS MIN.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
Fornestville		Regency Nursing Home		Prince George MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Film Editor		Motion Ind.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		P.G.		Marlow Heights	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
James Childs		Mary Hughes		4213-28th Ave.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		545-10-8486A		29058 Longview St., Warren, Michigan	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4292		Arteriosclerotic Cardio Vascular Disease			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
22a. I certify that (I) (this hospital) attended the deceased from 1975, 19, to 2-5, 1979, that (I) (we) last saw the deceased alive on 2-4, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED	
22b. SIGNATURE		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
John F. Shay, M.D.		5509 Old Silver Hill Rd, Suitland Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		2-8-79		Cedar Hill Cem.	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
Robt E Wilhelm		4308 Suitland Rd., Suitland, Md.		FEB 13 1979	

MEDICAL CERTIFICATION

99

BP



10-04988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-04987		
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR 02 20 1979 9 14 PM							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Roland H. Pannell					6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.							
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 11 5 24		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.						
7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.								
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince Georges Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CAB DRIVER		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN Wash. D.C.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 615 Lexington Pl, N.E.				
14. FATHER'S NAME FIRST MIDDLE LAST Preston Pannell					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Denia Williams							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Joseph Pannell - 825 46th St. N.E. Wash. D.C.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac and respiratory arrest 1579 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of pancreas DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE [Signature] DEGREE						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 2-20-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GABOR LAUFIER M.D.						22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2-26-79		23c. NAME OF CEMETERY OR CREMATORY Lincoln Mem. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Pr. Geo. Md.				
24. FUNERAL DIRECTOR NAME George R. Snowden				ADDRESS 246 N. Wash. St. Rockville, Md.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				

10-04083

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

January

Black

Proctor, Russell

John A. Williams  
C. L. Williams  
Joseph James Williams

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-04988	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH DAY YEAR			2b. HOUR		
HARRY JOHN PASEWARK JR.			FEB 22 79			6:35P			M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE		WHITE		MONTH DAY YEAR AUG 2 1928		50 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
KANSAS		USA				PRINCE GEORGES COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
ANDREWS AFB		MALCOLM GROW USAF MEDICAL CENTER				DIR OF CONTRACTS		GEORGETOWN U			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN											
13a. MARYLAND 13b. PRINCE GEO 13c. UPPER MARLBORO											
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				13e. STREET ADDRESS			
HARRY JOHN PASEWARK (D)				PALMYRA				9902 DALE DRIVE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
YES 1948-1965				510-26-1224		CARRIE M. PASEWARK (W) SAME AS ITEM 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <u>MYOCARDIAL INFARCTION</u>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>22 FEB</u> , 19 <u>79</u> , to _____, 19 _____, that (I) (we) lost <input checked="" type="checkbox"/> saw the deceased alive on _____, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Roy M. Kring						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 22 FEB 79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roy M. Kring						22e. ADDRESS MALCOLM GROW USAF MEDICAL CENTER ANDREWS AFB, MARYLAND 20331					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			2/26/79		Arlington Nat'l.		Ft. Myer Arlington, Va.				
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Lee Funeral Home, Clinton, Maryland 20735						FEB 27 1979		[Signature]			

10-01008

RECEIVED  
JAN 21 1950  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C.  
TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [illegible]  
RE: [illegible]  
[illegible text follows]

2/25/50  
[illegible text]  
[illegible text]  
[illegible text]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **79-04989**

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH		2b. HOUR	
RAY CARRICO PAYNE		2a. DATE KNOWN OF DEATH		2b. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH	
male		white		March 6, 1928	
6. AGE (IN YEARS LAST BIRTHDAY)		7. CITIZEN OF WHAT COUNTRY?		8. MARRIED	
50 YRS.		U.S.A.		NEVER MARRIED	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	
Maryland		Lanham		Doctor's Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13. STREET ADDRESS	
Trainer		Horses		P.O. BOX 64	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
Turner A Payne		Lucy Carrico		217-26-1323	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
R. Frances Payne same as 13		PART 1 DEATH WAS CAUSED BY:			
		IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease			
		DUE TO, OR AS A CONSEQUENCE OF			
		(b)			
		DUE TO, OR AS A CONSEQUENCE OF			
		(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Ann M. Dixon, M.D.		Assistant		2-16-79	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn St.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		2-22-79		Md. Veterans Cem.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS					
Huntt Funeral Home Waldorf, Maryland					



10-04302

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-04990	
1. FOR STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARGURETT PENDLEBURY</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>2 21 79</b>		2b. HOUR <b>12:50P M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan 18 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S COUNTY MD.</b>					
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGE'S GEN HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired-Vendor</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Fla.</b>		13b. COUNTY <b>Dade</b>		13c. CITY OR TOWN <b>Miami 33179</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1192 N.E. 196th St.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Meetre</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mabel Jenkins</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>None</b>		17. INFORMANT <b>Hollywood, Fla. 33024</b>		17. INFORMANT <b>John R. Pendlebury-son 1450 N. 64th Ave</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ileal loop &amp; pelvic node dissection</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Carcinoma of the Bladder</b> 1889										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>4/29</b> , 19 <b>79</b> , to <b>2/21</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>2/21</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Myron I. Murdock M.D.</b>				DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>2/22/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MYRON MURDOCK I.</b>				22e. ADDRESS <b>6911 LAUREL-BOWIE RD. BOWIE MD. 20715</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2-24-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Colmar Manor, Md.</b>					
24. FUNERAL DIRECTOR NAME <b>J. William Lee's Sons Co.</b>				ADDRESS <b>Wash. D.C. 20002</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 2 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McCready</b>			

BP

00040-01

2	13:00	1914	White	Washington, D.C.	USA	x	Hospital-Verif	3101 E. 16th St.	James	None	570-2-4213D John R. Pennington-son 1450 W. 6th Ave	Label	Moctre	14th	32770	x	3101 E. 16th St.	Hospital-Verif	2	13:00
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1. William Lee's Sons Co 300-4th St. E.  
 and D.E. 2000  
 Col. Pennington, MA.  
 1. William Lee's Sons Co 300-4th St. E.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-04991

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>HELENE NMI PERLROTH</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>02 05 79</b>		2b. HOUR <b>6:37p</b> M	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>05 08 33</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>45</b> YRS		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Connecticut</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES COUNTY</b> MD			
10. CITY OR TOWN OF DEATH <b>CLINTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTHERN MARYLAND HOSPITAL CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS <b>11511 Glissade Drive</b>			
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>PRINCE GEORGES</b>		13c. CITY OR TOWN <b>CLINTON</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>PHILIP LIPPMAN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BELLA SPECTOR</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>049-24-8073</b>		17. INFORMANT ADDRESS <b>IRVING PERLROTH (SAME AS # 13)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> 410- DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 DAYS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <b>1/30</b> , 19 <b>79</b> , to <b>2/5</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>2/5</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>P. W. Wisotsky</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>2/6/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>P. WISOTSKY</b>		22e. ADDRESS <b>AND</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>2/6/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>B'NAI ISRAEL CONGREGATION</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>OXON HILL P.G. MD.</b>		24. FUNERAL HOME NAME ADDRESS <b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b> <b>232 CARROLL STREET, N.W., WASHINGTON, D.C.</b>			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 79-04992	
1. FOR REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Richard Blane PHELPS Jr</b>										2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>2/24 1979</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9-2-08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2b. HOUR <b>M</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington D C</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD.	
10. CITY OR TOWN OF DEATH <b>Clinton</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Maryland Hosp. (DOR)</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Stone contracting co</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Owner</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
12a. STATE <b>Maryland</b>		12b. COUNTY <b>Prince Georges</b>		12c. CITY OR TOWN <b>Landover</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>455 Old Landover Rd</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Richard B Phelps Sr</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ellen B Halley</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>WW 11</b>		17. INFORMANT ADDRESS <b>Marion P Cook Arlington Va</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>Multiple injuries</b> IMMEDIATE CAUSE (a) <b>8129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>5:15 P.M. 2-24-1979</b>				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5:15 P.M. 2-24-1979</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Auto / Auto collision</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Street</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Pennsylvania Ave, Walls Corner, Ft. Greaser Md</b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>2-23-79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez</b>				ADDRESS <b>12800 Willow Wind Circle, Oxon Hill, Md. 20022</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Feb 28, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood Pro Georges Md.</b>	
24. FUNERAL DIRECTOR NAME <b>F. Gasch's Sons</b>				ADDRESS <b>P A Hyattsville, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 2 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Wm J. McCreedy</b>	

13-01002

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

MEMORANDUM FOR THE DIRECTOR

DATE: 10-15-54

TO: DIRECTOR

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

100-333333

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 79-04993	
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JULIAN P. PHILIBERT			February 12, 1979		2b. HOUR 9:45 AM
3 SEX MALE	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR OCT. 2, 1890	6. AGE (IN YEARS LAST BIRTHDAY) 88		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MISSOURI	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES CO. MD.		
10 CITY OR TOWN OF DEATH HYATTSVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL MANOR HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TELEPHONE CO. EMPLOYEE-		12b. KIND OF BUSINESS OR INDUSTRY C. & P.
13a. STATE VIRGINIA			13b. COUNTY ARLINGTON CO.	13c. CITY OR TOWN ARLINGTON	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST LEON DAVID PHILIBERT			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESTELLE PHILIBERT		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-05-0498	17. INFORMANT (SISTER) ADDRESS ARLINGTON, VA. MISS ESTELLE PHILIBERT-3402-3rd ST., N.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CVA					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo
436- DUE TO, OR AS A CONSEQUENCE OF (b) Central arteriosclerosis					years.
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Carcinoma of prostate					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 2-28, 1979, to 12 Feb, 1979, that (we) lost saw the deceased alive on 7 Jan, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Eugene J. Chap MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12 Feb 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. EUGENE J. CHAP		22e. ADDRESS 5272-RIVER RD., BETHESDA, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE FEB. 15, 1979		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY	
23d. LOCATION CITY OR TOWN WASHINGTON, D.C.		23e. STATE		23f. DATE REC'D. BY REGISTRAR FEB 16 1979	
24. FUNERAL DIRECTOR NAME HYSONG FUNERAL HOME-1300-N ST., NW WASH., DC		25b. REGISTRAR'S SIGNATURE [Signature]			



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CONFIDENTIAL - NO FORN DISSEM - NO COPY TO THE PRESS

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										79-04994 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Pote Anthony PHILLIPS</b>										2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>2/14 1979</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Sept 25-11 1928</b>		6. AGE (IN YEARS) <b>50</b> YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD.					
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8225 14th Avenue</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Security Guard</b>				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1414 Avenue of the 101</b>			
14. FATHER'S NAME <b>Massimo DeFilippo</b>				15. MOTHER'S MAIDEN NAME <b>Anina Del Aglio</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>579-10-5865</b>		17. INFORMANT <b>Ronald J. Phillips</b>				ADDRESS <b>Bowie, Md. 12606 Craft Lane</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic sclerotic cerebral vascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Chronic obstructive pulmonary disease</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>				TITLE (SPECIFY) <b>M.D. Deputy</b>				DATE SIGNED <b>2-16-79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez</b>				ADDRESS <b>15800 Willow Bend Circle, Tenafly, N.J.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb. 21, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Rockville</b> COUNTY <b>Mont.</b> STATE <b>Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>						25a. DATE REC'D BY REGISTRAR <b>FEB 22 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			
500 University Blvd., W. Silver Spring, Md.											

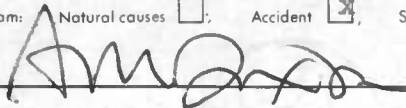

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												79-04995 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JAMES PATRICK PICKERAL</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>2 8/9 79</b>		2b. HOUR M <b>3:45 a</b>					
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12-18-61</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>17 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN. <b>17</b>		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>2 9 79</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Clinton</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Maryland Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpet Mech.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Carpet</b>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE <b>Md.</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Upper Marlboro</b>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET ADDRESS <b>11706 Van Brady Road</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Vernon Pickeral</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Patricia Rollins</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT ADDRESS <b>Charles Pickeral same as #13</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cold exposure complicating acute alcoholism</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>2/8-9 / 79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>"Froze" to death while intoxicated</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>woods</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Rt. 5 &amp; Surratts Rd. Clinton, P.G. Co., Md.</b>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. <b>Assistant</b> MEDICAL EXAMINER				DATE SIGNED <b>2-9-79</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>				ADDRESS <b>111 Penn St.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>2-12-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Mem. Garden</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Waldorf Charles Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Huntt Funeral Home Waldorf, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 15 1979</b>				25b. REGISTRAR'S SIGNATURE 					

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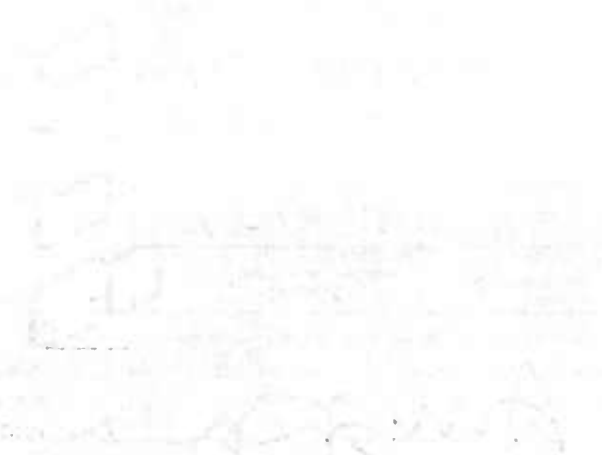
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04996

1. DECEASED NAME (TYPE OR PRINT) Robert Linwood Reavis		2a. DATE OF DEATH MONTH DAY YEAR February 2, 1979		2b. HOUR 6:45 P.M.	
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH MONTH DAY YEAR Aug. 10, 1919		6. AGE [IN YEARS LAST BIRTHDAY] 59 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.	
10. CITY OR TOWN OF DEATH Brandywine	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 3, Box 551, No. Keyes Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Policeman (Ret.)		12b. KIND OF BUSINESS OR INDUSTRY D. C. Gov't
USUAL RESIDENCE [IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION]					
13a. STATE Maryland	13b. COUNTY Pr. Geo.	13c. CITY OR TOWN Brandywine	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS Rt. 3, Box 551, No. Keyes Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Chester A. Reavis, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie M. Daniels			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II 577-18-3961		17. INFORMANT ADDRESS Dorothy E. Reavis, Wife SAA	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> <u>2019</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metabolic Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hodgkins Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 yrs</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1</u> , 19 <u>78</u> , to <u>2/2</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>1/22/79</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Stanley A. Schwartz</u>		DEGREE		22c. DATE SIGNED <u>2/3/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stanley A. Schwartz		22e. ADDRESS 106 Irving St., N. W.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/8/79		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham, Maryland		23e. DATE REC'D. BY REGISTRAR FEB 14 1979			
24. FUNERAL DIRECTOR McGuire Funeral Ser. <u>John F. McGuire</u>		ADDRESS 7400 Ga. Ave., N.W.		25. REGISTRAR'S SIGNATURE <u>Robert L. Reavis</u>	



800-0100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-04997

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
JAMES ELY REEVES		Male		Caucasian	
5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS	
1 MONTH 30 DAY 1924		55 YRS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Texas		U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
LANHAM		DOCTORS HOSPITAL OF P.G. CO.		Dairy Industry- Management	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN	
Md.		Pr. Geo.		Bowie	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13d. STREET ADDRESS	
James E. Reeves, Sr.		Elizabeth Perry		12914 Cheswood Lane	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS	
Yes		WW II 462-22-3037		Dixie A. Reeves Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Leukemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Preliminary Bone Marrow 1 1/2 yrs prior to cause of leukemia</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
2080 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs 8 months					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>15 Aug</u> 19 <u>77</u> to <u>29 Feb</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>24 Feb</u> 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If two) did (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Thomas A. Benninger MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		2/25/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Thomas A. Benninger MD		831 University Blvd E.S. 15th and			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		2-28-1979		Johnson Mem. Cem.	
24. FUNERAL DIRECTOR NAME		24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE	
Robert G. Beall Funeral Home		MAR 2 1979		Knox Texas	
9013 Annapolis Rd. Lanham, Md.					

10040-07

RECEIVED

U.S. DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D.C. 20250

TO :

FROM :

SUBJECT :

DATE :

BY :

FOR :

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NOTES :

1. This is a copy of the original document.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M/7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-04998  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		DATE KNOWN OF DEATH		HOUR	
Randi A. Reidner		2 12 19 79		M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.
female	white	Sept. 2, 1946	32 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	NEVER MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH	
Washington	U.S.A.	WIDOWED	DIVORCED	Prince George County MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Clinton	Clinton Community Hospital	Beautician	Beauty		
13a. STATE	13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?	13d. STREET ADDRESS		
Maryland	Charles	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	218 Gray Road		
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME				
Martin E. Norman	Annabelle Lohr				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS			
NO	560-68-4756	Jack L. Reidner same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cranio-cerebral Injuries					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					
(b) DUE TO, OR AS A CONSEQUENCE OF					
(c) DUE TO, OR AS A CONSEQUENCE OF					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
	12:30 P.M. 2 12 19 79	driver in auto/motorhome collision			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION			
	street	Piscataway Rd (12000 blk) Clinton PG Co., MD			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Virginia L. Dolan		Assistant		2/13/79	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Virginia L. Dolan, M.D.		111 Penn Street, Balto. MD 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Cremation	2-14-79	Metropolitan Crematory		Alexandria, Virginia	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Huntt Funeral Home		FEB 21 1979		History McCreedy	

See 10-21

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M/7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MATTIE SNYDER RENNER</b>												2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b># 2-18 19 79</b>	2b. HOUR M <b>12:10</b>	
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5-13-03</b>	6. AGE (IN YEARS) BIRTHDAY YRS. <b>75</b>	IF UNDER 1 YR. MONTHS DAYS <b>75</b>	IF UNDER 24 HRS. HOURS MIN. <b>75</b>	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>2-19 19 79</b>	7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>					7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES</b>
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NONE, GIVE STREET AND CITY OR TOWN) <b>PRINCE GEORGES GEN. HOSP. (DOA)</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>School Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>						
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>PRINCE GEORGES</b>		13c. CITY OR TOWN <b>Switzland</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5006 SILVER HILL ROAD</b>						
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harvey W. SNYDER</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rebecca MOYER</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>None</b>		17. INFORMANT <b>Jean SHERBONDY</b>		17a. ADDRESS <b>5816 Willow Oaks Dr, Richmond, Virginia</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>DUE TO, OR AS A CONSEQUENCE OF</b> (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>		TITLE (SPECIFY) <b>DEPUTY</b>		M.D. MEDICAL EXAMINER		DATE SIGNED <b>2-20-79</b>								
EXAMINER'S NAME (TYPE OR PRINT) <b>AUGUSTO P. RODRIGUEZ</b>		M.D.		ADDRESS <b>12800 WILLOW WIND CIRCLE, TANTLON, MD 20022</b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>Feb. 22, '79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Valley View Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Nokesville, Virginia</b>								
24. FUNERAL DIRECTOR NAME <b>IVES FUNERAL HOME INC.</b>		ADDRESS <b>2847 Wilson Blvd, Arlington, VA 22201</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 26 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia McBrady</b>								

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78

APR 19 1979

Division of Vital Records, 301 W. Preston St., Baltimore, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

4700

BP

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												79-05000 REG. NO.	
1- STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) <i>Ralph R. REYNOLDS</i>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 2-13 1979				2b. HOUR M			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>3-12-02 76</i>		6. AGE (IN YEARS) LAST BIRTHDAY YRS. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD 2-13 1979		2d. HOUR 11:43 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Kansas</i>				7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>PRINCE GEORGES</i> MD			
10. CITY OR TOWN OF DEATH <i>Cheverly</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prince Georges Hosp.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Communications</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Justice Dept.</i>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE <i>Md.</i>		13b. COUNTY <i>Prince Geo.</i>		13c. CITY OR TOWN <i>Mt. Ranier</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>4014 33rd St.</i>					
14. FATHER'S NAME FIRST MIDDLE LAST <i>James W. Reynolds</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Stella McAllister</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>515-10-3393</i>		17. INFORMANT ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <i>4392</i> IMMEDIATE CAUSE (a) <i>Coronary atherosclerotic cardiac vascular disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>Coronary artery, Mitral Regurgitation</i>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) <i>DEPUTY</i> MEDICAL EXAMINER				DATE SIGNED <i>2-15-79</i>					
EXAMINER'S NAME (TYPE OR PRINT) <i>AUGUSTO P. RODRIGUEZ</i>				M.D. ADDRESS <i>12800 WILLOW WIND CIRCLE TANTALLON, MARYLAND 20022</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>				23b. DATE <i>2/15/79</i>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME ADDRESS <i>Anatomy Board Balto., Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>FEB 21 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Barney McCready</i>							

00020-05

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

1911

REPORT OF THE SECRETARY

WASHINGTON, D. C.

1911

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corbanpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-05001	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
Mabel I. Rice					Feb. 28, 1979					2:10pm	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		Aug. 30, 1925		53 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Va.		U.S.A.				Pr. Geo. Co. MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Laurel		Greater Laurel-Beltsville Hospital				Book Keeper		Sand & Gravel Co.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			6 - Woodlawn Court # 204	
Md.			P.G.		Laurel						
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
William H. James					Ethel Mills						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS	
No					579 22 125 9		Gary Fleming (Son)			804 8th. St. # 104 Laurel, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Cardiac Arrest										In minute	
492- DUE TO, OR AS A CONSEQUENCE OF (b) Acute + Chronic Renal Failure										year	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Emphysema										years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
				HOUR A.M. MONTH DAY YEAR							
				P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>								STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Feb 5, 1979, to Feb 28, 1979, that (I) (we) lost saw the deceased alive on Feb 27, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE								DEGREE		22c. DATE SIGNED	
William Warren, M.D.								ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		March 1, 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)								22e. ADDRESS			
William Warren, M.D.								321 Prince George St. Laurel, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		STATE	
Burial				3-3-79		Ft. Lincoln Cemetery		Brentwood		P.G. Md.	
24. FUNERAL DIRECTOR NAME				4500 F. Gasch's Sons F.H. P.A. Hyatts. Md.				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
								MAR 5 1979		[Signature]	

10020-21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of force.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-05002	
FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
RUTH JANE RILEY						FEBRUARY 21 1979			8:50A <sub>M</sub>		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		WHITE		JULY 13, 1944 <sup>AR</sup>		34		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Washington D.C.		U.S.A.				Prince George's MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Lanham			Doctors' Hospital of Pr. Geo. Co.			Waitress			Hot Shopp Jr.		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Maryland			Prince Geo.			Lanham			5618 Whitfield Chapel Road		
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
John J. Brennan				Ruth Jane McGinley							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				168 36 4832		Larry D. Riley Same as #13 (Husband)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Failure and Hepatic Failure</u> <u>5715</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cirrhosis of the liver.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>pulmonary edema pleural effusion and Brain edema.</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>2-13-79</u> , 19 <u>79</u> , to <u>2-21</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>2-21-79</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>CHIN-CHUAN Hsu</u> M.D.						22c. DATE SIGNED <u>2/21/79</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CHIN-CHUAN Hsu</u>						22e. ADDRESS <u>6905 Baltimore Blvd Collegepark Md 20740</u>					
23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>			23b. DATE <u>2/23/79</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cem.</u>			23d. LOCATION CITY OR TOWN COUNTY STATE <u>Brentwood P.G. Md.</u>		
24. FUNERAL DIRECTOR <u>Francis Gasch's Sons F.H. P.A.</u> <u>Hyattsville, Maryland</u>						25. DATE REC'D. BY REGISTRAR <u>FEB 28 1979</u>			25b. REGISTRAR'S SIGNATURE <u>notary seal</u>		

MEDICAL CERTIFICATION

13-02005



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				Medical Examiner, or Rodriguez 79505003			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
FLORENCE E RUSSELL				02 28 79				12:30 A M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		WHITE		9 11 25		53		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				PRINCE GEORGES CLINTON, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Clinton		Southern Maryland Hospital Center				N/A Housewife		N/A. AT HOME			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			
Md.				P.G. County		Temple Hills		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				13e. STREET ADDRESS			
James Shelby Brightwell				Mary Padgett				3446 Brinkley Rd. Temple Hills, Md.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No.				NONE		Son/ARTHUR RUSSELL		3446 Brinkley Rd. Temple Hills			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic shock, cardiorespiratory arrest</u> 440- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <u>Anteroseptal M.I. and Complete heart block.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>2, 27</u> , 19 <u>79</u> to <u>2, 28</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>2, 28</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
M. NEMATE, M.D.				/ Attending Physician, Dr. Mostaan						2, 28, 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
M. NEMATE, M.D.				4235, 28th Ave. Marlow Heights, Md. 20031							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
BURIAL				3/3/79		FT. LINCOLN CEM		BRENTWOOD			
24. FEDERAL DIRECTOR				25. DATE REC'D BY REGISTRAR							
F. H. 6/6				5/19/79							



100-20-000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

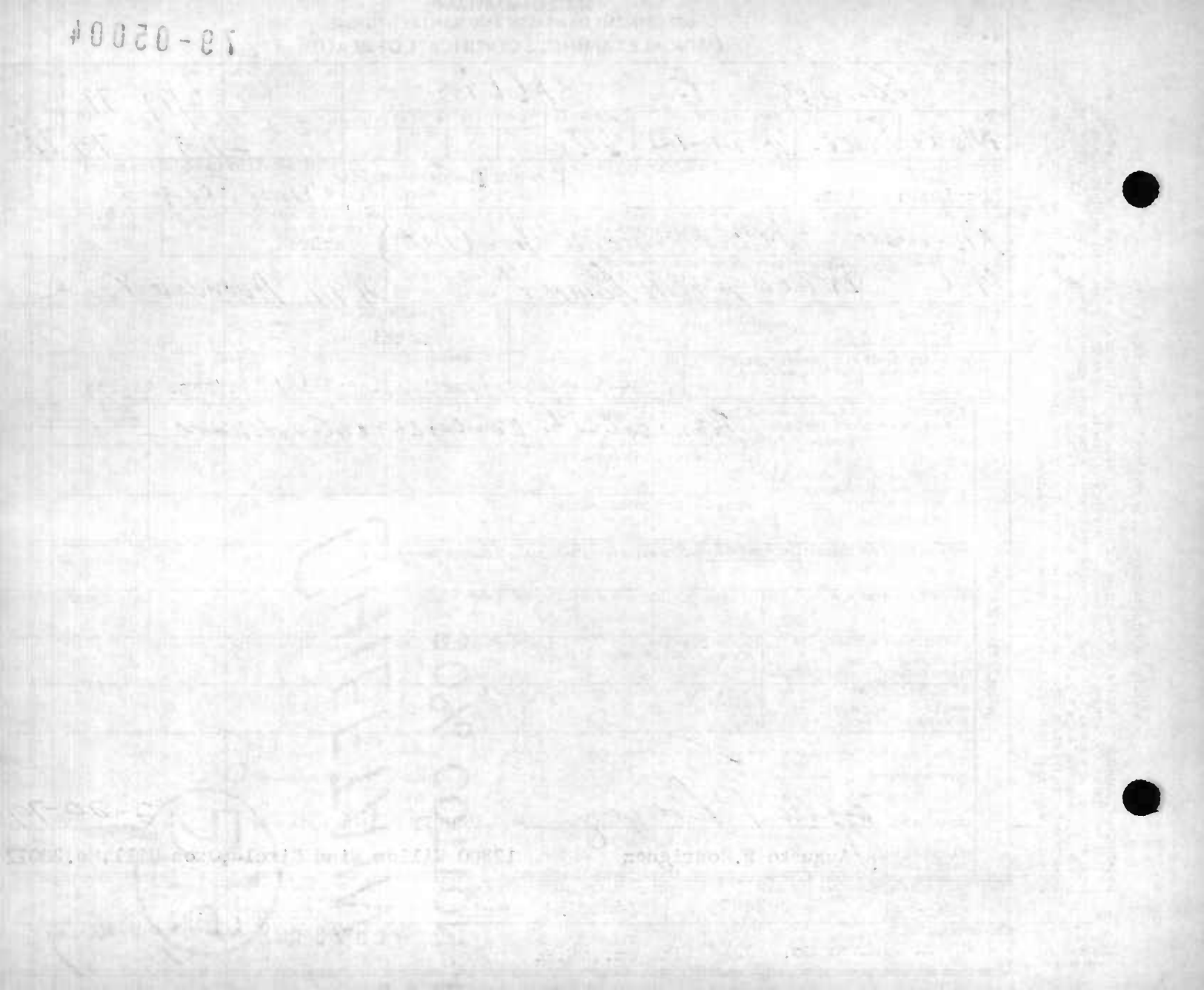
REG. NO. 79-05004

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		2b. HOUR
Samuel		G.	SALLIS		2/19 79		M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD
Male	Black	10-19-14		64 YRS.			2/19 79
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Kosciusko, Miss.		USA				Primer, George	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Riverdale		Roland Memorial Hosp. (Det)		Retired		None	
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. CITY OR TOWN		13c. STREET ADDRESS	
Md. Dr. George M. Lammers				4911		Avondale Road	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
Will Sallis				Kattie Ross			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes				209-09-9169		Martha I. Sallis/wife/same as 13c	
18. CAUSE OF DEATH (Enter only one cause pending for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 } Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED			
Augusto P. Rodriguez		Deputy		2-20-79			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			
		12800 Willow Wind Circle, Oxon Hill, Md. 20022		Burial			
23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
2-24-79		Lincoln Memorial		Suitland, Md.			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
John T. Rhines Co., 3015 12th St., N.E., D. C.				FEB 25 1979		[Signature]	

BP

10020-01



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 79-05005	
1 DECEASED NAME (TYPE OR PRINT) <b>BABY GIRL SANDERS</b>			2a DATE OF DEATH MONTH DAY YEAR <b>1/31/79</b>		2b HOUR <b>00:30</b> M
3 SEX <b>F</b>	4 RACE <b>BLACK</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>1 30 79</b>	6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>2</b>		IF UNDER 1 YEAR IF UNDER 24 HRS.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 <b>BALTIMORE CITY</b> OR COUNTY OF DEATH <b>P.G.</b> MD.		
10 CITY OR TOWN OF DEATH <b>Cheverly</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGES COUNTY</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY
13a STATE		13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: <b>7651</b> IMMEDIATE CAUSE (a) <b>PREMATURITY</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Debellappa MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/31/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D. CHELLAPPA</b>		22e ADDRESS <b>P.G.G. HOSPITAL</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>cremation</b>		23b DATE <b>3/7/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prince George's Hospital</b>	
				23d LOCATION CITY OR TOWN COUNTY <b>Cheverly, P.G. Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Raleigh Cline, Cheverly, Maryland</b>			25a. DATE REC'D. BY REGISTRAR <b>MAR 13 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Rafael McCready</b>

20020-05

20020-05

20020-05



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-05006

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Leah C. Sanford</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2 25 1979</b>			2b. HOUR <b>4:46 pm</b>					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 30 24</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		7. IF UNDER 24 HRS HOURS MIN. <b>0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George</b> MD.					
10. CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Maryland Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Adm. Tech.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Govt.</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Clinton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6509 Old Alexander Ferry Rd.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>George W. Hart</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nellie A. Hart</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>579-20-0934</b>		17. INFORMANT ADDRESS <b>John H. Sanford (Husband) Same as item 13a</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b> <b>410-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>severe atherosclerotic coronary heart disease</b> (c) <b>ventricular aneurysm</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>years</b> <b>months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Exaggerated obesity</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 25</b> 19 <b>79</b> , to <b>Feb 25</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>Feb 25</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Peter W. Yim M.D.</b>				DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>2-25-79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PETER W. YIM M.D.</b>				22e. ADDRESS <b>7900 Old Branch Ave Suite 101 Clinton, Maryland 20735</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2-28-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Christ Church Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clinton P.G. Maryland</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 27 1979</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-05007		
1. FOR STATE REGISTRAR					2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR		
1 DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST			February 14, 1979		1:00A <sub>M</sub>		
3 SEX					4 RACE		5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)		
Male					Cauc.		Oct. 22, 1924			54		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH		
Tenn.					U.S.A.					Prince Georges MD.		
10 CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly					Prince Georges Hospital			Secret Service			U.S. Gov't.	
13a. STATE					13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Maryland					Prince Georges		Riverdale			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME					15 MOTHER'S MAIDEN NAME			13e. STREET ADDRESS				
FIRST MIDDLE LAST					FIRST MIDDLE LAST			6029 67th Place				
Carl P. Sauls					Sarah F. Williams							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS					
yes					WW 11		121-22-6506 Waunitau C. Sauls, 6029 67th Pl., Maryland					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver Failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
1729 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Massive Hepatic Replacement by metastatic												
DUE TO, OR AS A CONSEQUENCE OF (c) malignant melanoma												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
					HOUR A.M. MONTH DAY YEAR							
					P.M. 19							
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION				
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>								STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 2/13, 19 79, to 2/14, 19 79, that (we) lost												
saw the deceased alive on 2/13, 19 79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.												
22b. SIGNATURE					DEGREE					22c. DATE SIGNED		
D. Granite MD					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					2/15/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS							
D. Granite MD					Greenbelt Prof. Building, Greenbelt, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION				
Burial			Feb. 16, 1979		Md. Veterans Cem.			Cheltenham, Maryland				
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Robert C. Beall Funeral Home					FEB 26 1979							
9013 Annapolis Road, Lanham, Maryland												

FUNERAL DIRECTOR

ADDRESS

DATE REC'D. BY REGISTRAR

REGISTRAR'S SIGNATURE

13-02003

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-05008

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>KATHRYN CHALMERS SAUR</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>02 05 79</b>			2b. HOUR <b>6:35p</b> M	
3. SEX <b>female</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 13 98</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>80</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>CLINTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTHERN MARYLAND HOSPITAL CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Telephone operator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>A C F</b>	
13a. STATE <b>MARYLAND-PRINCE GEORGES</b>				13b. COUNTY <b>HYATTSVILLE</b>		13c. CITY OR TOWN	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Minson</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>? Goodson</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>577-34-1956</b>		17. INFORMANT ADDRESS <b>Henry A Saur Hyattsville, Md.</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspirin Pneumonia</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Liver Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Bicuspid Aortic Valve</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>2-5</b> 19 <b>79</b> , to <b>2-5</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>2-5</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>[Signature]</b>				DEGREE		22c. DATE SIGNED <b>2-6/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CIRO A. MONTANEZ</b>				22e. ADDRESS <b>3308 Dodge PK Rd Lanham</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb 9, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington D C</b>	
24. FUNERAL DIRECTOR NAME <b>F. Gasch's Sons P A Hyattsville, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 8, 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17  
(VR A15 ME (5))  
15M 7/77

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 79-05009			
1. DECEASED NAME (TYPE OR PRINT) <i>Agnes H. SAVOY</i>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 2-21 1979										2b. HOUR M			
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>3 08 - 65</i>		6. AGE (IN YEARS) (LAST BIRTHDAY) <i>23</i> YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD <i>2-21 79</i>										2d. HOUR M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>				7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <i>Ames Georges</i>										MD.	
10. CITY OR TOWN OF DEATH <i>Clinton</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Southern Maryland Hosp. (DOH)</i>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <i>Md.</i>										13b. COUNTY <i>P. George</i>		13c. CITY OR TOWN <i>Aquasco</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>Rt. 1-Box 56</i>							
14. FATHER'S NAME FIRST MIDDLE LAST <i>Michael Proctor</i>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Suzanna Butler</i>													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>				16b. SOCIAL SECURITY NO. <i>217-366362</i>				17. INFORMANT ADDRESS <i>Elsie Green-Aquasco, Md.</i>															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diabetic arteriosclerotic cardiovascular disease</i> 2500 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>Hypertension &amp; peripheral vascular disease</i>																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?																20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																							
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) <i>Deputy</i>				DATE SIGNED <i>2-22-79</i>															
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez</i>				12800 Willow Wind Circle, Oxon Hill, Md. 20022																			
23a. BURIAL, CREMATION, REMOVAL (TYPE) <i>Burial</i>				23b. DATE <i>2/26/79</i>				23c. NAME OF CEMETERY OR CREMATORY <i>St. Peter's Ch. Cem</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Waldorf Chris Md.</i>											
24. FUNERAL DIRECTOR NAME <i>Adams Funeral Home</i>				ADDRESS <i>Adams Funeral Home</i>				25a. DATE REC'D. BY REGISTRAR <i>MAR 2 1979</i>				25b. REGISTRAR'S SIGNATURE <i>Robert A. Brady</i>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-05010	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>RUTH K. SCHUHART</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>2/25/79</b>			2b. HOUR <b>10:25 P</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 9, 1928</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>50</b>		7. UNDER 1 YEAR MONTHS DAYS <b></b>		7b. UNDER 24 HRS. HOURS MIN <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>P.G.</b> MD.					
10. CITY OR TOWN OF DEATH <b>RIVERDALE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LELAND MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b></b>			12b. KIND OF BUSINESS OR INDUSTRY <b></b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Md.</b>						13c. COUNTY <b>P.G.</b>		13d. CITY OR TOWN <b>Hyattsville</b>		13e. STREET ADDRESS <b>7732 Frederick Rd. 20784</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Harry Knott</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice Elizabeth Thompson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>579-36-5986</b>		17. INFORMANT ADDRESS <b>William E. Schuhart Same as 13e.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Small cell cancer of the lung</b> <b>1629</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 mos.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b></b>											
19a. DATE OF OPERATION <b>9/9</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b></b>				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b></b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b></b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> <b></b>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b></b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b></b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec. 79</b> to <b>2-25</b> , 19 <b>78</b> , that (I) (we) lost saw the deceased alive on <b>2-24</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Kai-Yin Yeung</b>						DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2-26-79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Kai-Yin Yeung M.D.</b>						22e. ADDRESS <b>6525 Belmont Rd #460 Hyattsville MD 20782</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>3/1/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bushwood St. Mary's MD.</b>			
24. FUNERAL DIRECTOR NAME <b>W. Clarke Mattingley</b>						ADDRESS <b>Leonardtwn, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 01 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert M. B...</b>	

3623 BP



19-02010

SCHEMATIC

K.

RUMI

LELAND MEMORIAL HOSPITAL

RIVERDALE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR												DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 79-05011	
1. DECEASED NAME (TYPE OR PRINT)		FIRST Vincent		MIDDLE		LAST SCALETTA		2a. DATE KNOWN OF DEATH		ESTI-MATED		MONTH DAY YEAR		2b. HOUR			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8-25-88		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 90		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR 2-2 1979			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.											
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Prince Georges General Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Barber-Self-Employed		12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Md.		13b. COUNTY Prince Georges		13c. CITY OR TOWN Mt. Rainier		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 25th Street									
14. FATHER'S NAME FIRST MIDDLE LAST Pasquale Scaletta				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Camella Zavitteri				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No -				16b. SOCIAL SECURITY NO. 577-05-3405A					
17. INFORMANT Mrs. Anita E. Scaletta				ADDRESS same as above													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Abdominal aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Right hip fracture</u> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>Right hip fracture</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE <u>Augusto P. Rodriguez</u>				TITLE (SPECIFY) <u>Deputy</u>				DATE SIGNED <u>2-2-79</u>									
EXAMINER'S NAME (TYPE OR PRINT) <u>Augusto P. Rodriguez</u>				ADDRESS <u>17800 Willow Bend Circle, Oxon Hill, Pr. Geo. Md.</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-5-1979		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.									
24. FUNERAL DIRECTOR Nalley's F.H. Inc.				ADDRESS Mt. Rainier, Md.				25a. DATE REC'D. BY REGISTRAR FEB 6 1979									
				25b. REGISTRAR'S SIGNATURE <u>Anthony McCready</u>													

11020-05

RECEIVED  
FEB 10 1975

11020-05

DATE	DESCRIPTION	AMOUNT
1/15/75	...	...
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12/30/75	...	...



FEB 10 1975

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TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-05012

1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
GUY			LEROY	SCHULTZ, Sr.	02	07	79	10:57P.M.	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Male	Caucasian	12 28 00		78	MONTHS		DAYS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Washington DC	USA			Prince Georges				MD.	
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY				
Clinton	SOUTHERN MARYLAND HOSPITAL CENTER		Retired		Grocer				
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS	
Maryland		Pr. Georges		Clinton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8805 Old Branch Avenue	
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
Charles G. Schultz		Gertrude		Brown					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS			
no		220-32-6205		Mildred C. Cissel		Same as 13 a-e			

18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> 3352 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>PROGRESSIVE AMYOTROPHIC</u> (c) <u>LATERAL SCLEROSIS</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>FEW HRS</u> <u>FEW YRS</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:	
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED
20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f LOCATION STREET	CITY OR TOWN
COUNTY	STATE
22a I certify that (I) (this hospital) attended the deceased from <u>Feb 7</u> , 19 <u>79</u> , to <u>Feb 7</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>Feb 7</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b SIGNATURE <u>M. SEREMETIS, MD</u>	22c DATE SIGNED <u>2-13-79</u>
22d PHYSICIAN'S NAME (TYPE OR PRINT)	22e ADDRESS
<u>M. SEREMETIS, MD</u>	<u>3301 NEW MEX. AVE. NW-WASH. D.C.</u>
23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE
Burial	2/10/79
23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN
Resurrection	Clinton, P.G., Md.
24 FUNERAL HOME	25a DATE REC'D. BY REGISTRAR
<u>Lee Funeral Home, Clinton, Maryland</u>	<u>FEB 15 1979</u>
25b REGISTRAR'S SIGNATURE <u>Phyllis McCreedy</u>	

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH79-05013  
REG. NO.

1- STATE REGISTRAR		2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2. DATE KNOWN OF DEATH		2b. HOUR	
Richard H. Scrivner				2. DATE KNOWN OF DEATH		2b. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)	
Male		Black		Feb. 28, 1923		55 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Upper Marl., Md.		United States				Prince George's County, MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly		Prince George's General Hospital		Maintenance Worker		Gov't.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Maryland		P. G.		Landover,		7318 Landover Road,	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Richard		Estelle		no		220-28-3790	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
Mrs. Elizabeth Scrivner/wife/1922 Rochelle		PART 1 DEATH WAS CAUSED BY:				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		IMMEDIATE CAUSE (a) Gunshot wound of chest					
		DUE TO, OR AS A CONSEQUENCE OF					
		(b)					
		DUE TO, OR AS A CONSEQUENCE OF					
		(c)					
		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
:19xxx 2 17 19 79		shot by assailant					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
		home		7318 Landover		Landover P.G. MD	
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from:		Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		TITLE (SPECIFY)		DATE SIGNED	
ACTUAL SIGNATURE		M.D.		Deputy Chief		2/18/79	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn St.		Balto., MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		Feb. 22, 1979		Harmony Cemetery		Landover P.G. MD	
24. FUNERAL DIRECTOR NAME		ADDRESS		4339 New		DATE RECEIVED BY REGISTRAR	
Collins Inc.		P.O. Box				MAR 7 1979 REGISTRAR'S SIGNATURE	

10-02013

UNITED STATES

RECEIVED

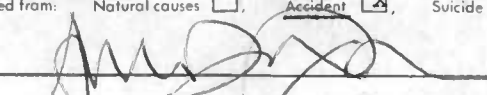



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-05014

1. FOR STATE REGISTRAR		FIRST John		MIDDLE F.		LAST Sewell		2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 2 1 19 79		2b. HOUR M 1:22 P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 29 02		6. AGE (IN YEARS) (LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2 1 19 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.	
10. CITY OR TOWN OF DEATH Clinton				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY U S Gov't	
13a. STATE Maryland				13b. COUNTY Pr Geo		13c. CITY OR TOWN Hillcrest Hts		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4311 23rd Parkway	
14. FATHER'S NAME FIRST MIDDLE LAST Franklin Sewell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leota Hughes							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----		17. INFORMANT Hazel Sewell (wife)				ADDRESS Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <u>Blood Transfusion Reaction</u> IMMEDIATE CAUSE (a) <u>8760</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 2 1 19 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject received four units of wrong blood group					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hospital		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Southern Maryland Hospital, Clinton, Prince George's, Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				M.D. Assistant				MEDICAL EXAMINER		DATE SIGNED 2/2/79	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5Feb1979		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md.	
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm Funeral Home				ADDRESS Suitland, Md.				25a. DATE REC'D. BY REGISTRAR FEB 8 1979		25b. REGISTRAR'S SIGNATURE 	

MEDICAL CERTIFICATION

41020-01

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DMMH - 17  
(VR A15 ME (5))  
15M/7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 79-05015

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE PRONOUNCED DEAD		2d. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		MONTH DAY YEAR	
Francis Arthur SHERMAN		1-31 1979		1-31 1979	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.
Male	White	MONTH DAY YEAR	LAST BIRTHDAY	MONTHS DAYS HOURS MIN.	
		1-7-20 59 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	NEVER MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH	
Massachusetts	USA	WIDOWED	DIVORCED	Bowie Georges	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Lanham	Doctors Hospital of P.G. (DHA)	Printing co		Stationer	
13a. STATE	13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?	13d. STREET ADDRESS		
Md.	Pro Georges	YES <input type="checkbox"/> NO <input type="checkbox"/>	1206 Port Echo Lane		
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST	FIRST MIDDLE LAST				
Arthur E Sherman	Emma Whitten				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS	
Yes	WW 11	Edith Wherman		Bowie, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a)					
4392 Arteriosclerotic cardiovascular disease					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).					
Diabetes mellitus, Shers during exercise					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?
					YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Augusta P. Rodgers		Regent		2-1-79	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Augusta P. Rodgers					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION COUNTY STATE	
cremation	Feb 3, 1979	Ft Lincoln Crematory		Brentwood Pro Georges Md.	
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR		
F. Gasch's Sons P A Hyattsville, Md.			FEB 6 1979		
			25b. REGISTRAR'S SIGNATURE		
			History McCreedy		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-05016	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <u>SILVESTER (NME) SHORTER</u>					2a. DATE OF DEATH		MONTH <u>2</u> DAY <u>8</u> YEAR <u>79</u>		2b. HOUR <u>10:20</u> P.M.		
3. SEX <u>MALE</u>		4. RACE <u>NEGROID</u>		5. DATE OF BIRTH MONTH <u>5</u> DAY <u>22</u> YEAR <u>14</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>64</u> YRS.		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		IF UNDER 24 HRS HOURS <u></u> MIN <u></u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>YES-USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>PRINCE GEORGE'S</u> MD.					
10. CITY OR TOWN OF DEATH <u>CLINTON, Md</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>CLINTON COMMUNITY HOSPITAL</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <u>Maryland</u>		13b. COUNTY <u>P.G.</u>		13c. CITY OR TOWN <u>WALDOAS</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <u>Route 2 Box 216</u>			
14. FATHER'S NAME FIRST <u>Alexander</u> MIDDLE <u>Shorter</u> LAST <u></u>				15. MOTHER'S MAIDEN NAME FIRST <u>Mary A.</u> MIDDLE <u>Byles</u> LAST <u></u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>220-09-6207</u>		17. INFORMANT <u>Hazel Shorter</u>				ADDRESS <u>SAA</u>			
18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Septicemia - ASH.D.</u>											
DUE TO, OR AS A CONSEQUENCE OF <u>CVA</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF <u>Hypertension</u>											
(c) <u></u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>M. Moasser</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M. Moasser</u>				22e. ADDRESS <u>Clinton Community Hosp.</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <u>2/12/79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph Ch. Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Parm Fretts Chas Md.</u>					
24. FUNERAL DIRECTOR NAME <u>Adams Funeral Home</u>				ADDRESS <u>RT 1 Box 185</u>		25a. DATE REC'D. BY REGISTRAR <u>FEB 15 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Mary M. Cuddy</u>			

13-02016

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-05017

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Barbara Mae SKEELE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 7, 1979</b>		2b. HOUR <b>12:25pm</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>October 26, 1886</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS # UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince-Georges</b> MD.		
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sacred Heart Home</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md</b> 13b. COUNTY <b>Pro Georges</b> 13c. CITY OR TOWN <b>Cheverly</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2804 Crest ave</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Richard E. Ruth</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Dietrich</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>5792 48338</b>		17. INFORMANT ADDRESS <b>Marian S. Curran Cheverly Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Melanotic carcinoma</b> <b>1539</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of colon</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>over 2 yrs</b> <b>over 1 yr</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION <b>1975</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma of colon</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>1960</b> , 19____, to <b>2-6-79</b> , 19____, that (I) <del>was</del> last saw the deceased alive on <b>2-6</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>John H. Kehge</b> DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2-7-79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN KEHGE</b>				22e. ADDRESS <b>6300 Riverdale Rd Riverdale.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>FEB 8, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BRENTWOOD P.G. Md.</b>		
24. FUNERAL DIRECTOR NAME <b>F. GASCH'S SONS, HYATTSTVILLE, Md</b> ADDRESS				25a. DATE REC'D. BY REGISTRAR <b>FEB 13 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-05018
1. FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST STACY Gum SKIDMORE						2a. DATE OF DEATH MONTH DAY YEAR 02 24 79		2b. HOUR 8:40A M		
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 1, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.				
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GENERAL HOSPITAL				12. PRESENT OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Building & Grounds		12b. KIND OF BUSINESS OR INDUSTRY Government		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland						13b. COUNTY Prince Geo		13c. CITY OR TOWN Riverdale		
14. FATHER'S NAME FIRST MIDDLE LAST Unknown						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 230 10 8113		17. INFORMANT 4115 Farragut Street Elizabeth Jarman Hyattsville, Maryland						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Sepsis</u> 3240 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost { (b) <u>Probable subdural brain abscess</u> DUE TO, OR AS A CONSEQUENCE OF { (c) <u>?</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>? 2 weeks</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Respiratory Failure, Staph Aureus Sepsis, obstructive vropathy,</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>12/19</u> , 19 <u>79</u> , to <u>2/24</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>2/23</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>[Signature]</u> M.D. DEGREE						22c. DATE SIGNED <u>2/24/79</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEVEN M POLLAK M.D.		
22e. ADDRESS <u>4700 14TH PLACE CAMP SPRINGS</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/27/79		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Md.				
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland						25a. DATE REC'D. BY REGISTRAR MAR 01 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

MEDICAL CERTIFICATION

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STACY

6:00

Jan. 1, 1970

W. H. S.

W. H. S.

PRINCE GEORGES

W. H. S.

W. H. S.

PRINCE GEORGES GENERAL HOSPITAL

CLEVELAND

100 Greenway Road

Prince Georges River

W. H. S.

11-3-73  
Sylvanville, Pa. 151

has been taken

2-10-73

10

11-3-73

Lincoln Co.

11-3-73

Initial

has been taken

11-3-73

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-05019						
1. FOR STATE REGISTRAR					2a. DATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)					FIRST		MIDDLE		LAST		MONTH	DAY	YEAR	2b. HOUR		
ADELLE SMITH					2		8		79		10:30AM					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS						
F		B		4 - 6 - 1959		19 YRS.		MONTHS		DAYS		HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH										
Md.		U.S.A.				PRINCE GEORGE'S COUNTY MD.										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
CHEVERLY		PRINCE GEORGE'S GEN HOSPITAL								None		None				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?					13e. STREET ADDRESS						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1203 Cap. View Dr. #1722								
Md.		P.G.		Landover												
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME											
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST						
Leon				Smith		Rose				Thompson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS						
No					215-70-9060					Rose Smith-Same as # 13 above						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) Cerebral Anoxia																
6339 DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac pulmonary Arrest																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																
DUE TO, OR AS A CONSEQUENCE OF (c) Shock 2° to Ectopic Pregnancy Rupture																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
										YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
					P.M. 19											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 2-4 19 79 to 2-8 19 79, that (I) (we) last saw the deceased alive on 2-8 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE										DEGREE		22c. DATE SIGNED				
[Signature]										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		2/9/79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS						
JOSEPH COLELLA										PGGH/MC CHEVERLY, MD. 20785						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE						
Burial					2-14-79		Harmony Mem. Cem.			Highland Park, Md.						
24. FUNERAL DIRECTOR NAME										ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE	
Kenneth D. Washington										4925 N.H. Ave		FEB 16 1979			[Signature]	

MEDICAL CERTIFICATION

99

3502 BP

22-02018

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-05020

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CORA L SMITH</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2 3 79</b>		2b. HOUR <b>1:40P M</b>	
3 SEX <b>Female</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3/28/1910</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		8. IF UNDER 24 HRS HOURS MIN <b>YRS.</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10 CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGE'S GEN HOSPITAL</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S COUNTY MD.</b>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>				
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>W. Va.</b>						
13b. COUNTY <b>McDowell</b>		13c. CITY OR TOWN <b>Roderfield</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS <b>P.O. Box 251</b>						
14. FATHER'S NAME FIRST MIDDLE LAST <b>Patrick Sopsher</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Laura Doby</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>235 36 8512</b>		17. INFORMANT ADDRESS <b>Billy Smith Roderfield, W. Virginia</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MASSIVE MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>410-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)						
<b>Diabetes Mellitus</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>2-3-79</b> , 19 <b>79</b> , to <b>2-3</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>2-3</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.						
22b. SIGNATURE <b>Gerard Sweeney MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>2-5-79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Gerard Sweeney</b>		22e. ADDRESS <b>Prince George Hospital Cheverly, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/7/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ieager Cemetery</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Roderfield McDowell, W. Va.</b>						
24. FUNERAL DIRECTOR NAME <b>Nalley Funeral Home Mt. Rainier, Md.</b>		ADDRESS <b>25a. DATE REC'D BY REGISTRAR</b> <b>FEB 8 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Gerard Sweeney</b>		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



19-02020

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PRINCE GEORGE'S COUNTY

PRINCE GEORGE'S GEN HOSPITAL

CHEVERLY

1.0. Box 251

1.0. Box 251

1.0. Box 251

ACUTE MASSIVE MYOCARDIAL INFARCTION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-05021  
REC. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Ray Matthew SMITH</i>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <i>2-12-79</i>			2b. HOUR <i>M</i>			
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH <i>9</i> DAY <i>24</i> YEAR <i>23</i>	6. AGE (IN YEARS) YEARS <i>55</i>	IF UNDER 1 YR. MONTHS <i></i> DAYS <i></i>	IF UNDER 24 HRS. HOURS <i></i> MIN. <i></i>	2c. DATE PRONOUNCED DEAD <i>2-12-79</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i>			10. CITY OR TOWN OF DEATH <i>Suitland</i>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>3506 Parkway Terr. Dn.</i>			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>SELF-EMPLOYED</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>FARMING</i>			13a. STATE <i>MD.</i>			
13b. COUNTY <i>PR. GEO.</i>			13c. CITY OR TOWN <i>SUITLAND</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS <i>3506 Parkway Terr. Dn.</i>			14. FATHER'S NAME FIRST <i>Charles</i> MIDDLE <i>J.</i> LAST <i>Smith</i>			15. MOTHER'S MAIDEN NAME FIRST <i>Amanda</i> MIDDLE <i>E.</i> LAST <i>Windsor</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>218-38-8321</i>			17. INFORMANT ADDRESS <i>MARY WINDSOR SAME AS ITEM 13</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral selective cardiac vascular disease</i> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>Appl. conditions, renal lithiasis</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE <i>August P. Rodriquez</i>			TITLE (SPECIFY) <i>MD. Deputy</i>			DATE SIGNED <i>2/12/79</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>August P. Rodriquez</i>			ADDRESS <i>6800 Wilburville Rd., Timonium, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>2-15-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Ave</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Brentwood Md.</i>		
24. FUNERAL DIRECTOR NAME <i>G.P. Kolas</i>			ADDRESS <i>6160 OXON HILL RD. OXON HILL, MD.</i>			25a. DATE REC'D. BY REGISTRAR <i>FEB 15 1979</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

10-02051

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH79-05022  
REG. NO.1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Ronald C. SMITH</b>		2a DATE OF DEATH MONTH DAY YEAR <b>February 20, 1979</b>		2b HOUR MIN <b>4:00 A</b>	
3 SEX <b>MALE</b>		4 RACE <b>BLACK</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>NOV. 2, 1973</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASH. D.C.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <b>5</b>	
10 CITY OR TOWN OF DEATH <b>Glenn Dale</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Glenn Dale Hospital</b>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges County MD</b>	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NONE</b>		12b KIND OF BUSINESS OR INDUSTRY <b>NONE</b>			
13a STATE <b>D.C.</b>		13b COUNTY <b>WASH.</b>		13c CITY OR TOWN <b>WASH.</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>HENRY WHITLEY</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BRENDA SMITH</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. <b>NONE</b>		17 INFORMANT ADDRESS <b>LOIS SIMMS 1 NEW YORK AVE. N.W. D.C.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute respiratory failure</b> 4321 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Chronic bilateral subdural hematoma</b> (c) <b>Due to, or as a consequence of</b> 4 years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Convulsive disorders</b>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Sept 1, 1977</b> , to <b>Feb. 20, 1979</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Feb. 20, 1979</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.					
22b. SIGNATURE <i>James W. Wills</i>				22c. DATE SIGNED <b>Feb. 20, 1979</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James W. Wills, M.D.</b>				22e ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland 20769</b>	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>2-28-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wash. Nat'l Cem.</b>	
23d. LOCATION CITY OR TOWN <b>SUITLAND,</b>		COUNTY <b>P.G.C.</b>		STATE <b>Md.</b>	
24 FUNERAL DIRECTOR NAME <b>W. W. CHAMBERS CO.</b>		ADDRESS <b>517 11th ST. S.E.</b>		25. DATE RECEIVED BY REGISTRAR <b>MAR 2 1979</b>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on file.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

18-02025

NOV. 2, 1973

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WASH. D.C.

W. P. CHAMBERS CO. 217 HIGH ST. S.E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 79-05023	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST		
THOMAS E. SMITH			2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR
3. SEX Male		4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer	12b. KIND OF BUSINESS OR INDUSTRY Tobacco
13a. STATE Md.			13b. COUNTY Pr. Geo.	13c. CITY OR TOWN Mitchellville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William Francis Smith			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura C. Perrie		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) n/a	17. INFORMANT ADDRESS Mary E. Smith Same as # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral left heart failure</u> 4151 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Cerebral myocardial infarction</u> (c) <u>Pulmonary Embolus</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2-25-79, 19 79, to 2/26/79, 19 79, that (I) (we) last saw the deceased alive on 2/26/79, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE T.J. Hernandez		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T.J. Hernandez MD		22e. ADDRESS PGGH & MC, Cheverly, 20785		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 01 MAR 79		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	
23d. LOCATION CITY OR TOWN Annapolis, Maryland		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME Robert G. Beall		ADDRESS 9013 Annapolis Rd. Lanham, Md. 20801		25a. DATE REC'D. BY REGISTRAR 5 MAR 1979	
				25b. REGISTRAR'S SIGNATURE [Signature]	

19-05023

12-1-72

SMITH

THOMAS

1901-01-1910

1901-01-1910

PRINCE GEORGE'S

U.S.A.

NAVY

PRINCE GEORGE'S GENERAL HOSPITAL

QUEENSLAND

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 79-05024

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		02 09 79		10:50 P <sup>M</sup>	
Barbara Stackhouse							
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
FEMALE		BLK.		MONTH DAY YEAR		36 YRS.	
2 7 43							
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
D.C.		USA				PRINCE GEORGE'S COUNTY MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
CHEVERLY		EXTENDED CARE FACILITY		NURSE			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MD		PG		HANDOVER		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
FRED		MARY		NO		UNK	
17 INFORMANT		ADDRESS		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Katie Riepley		8606 Hamlin St.		Terminal renal cell Ca			
1890				DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b)			
				DUE TO, OR AS A CONSEQUENCE OF			
				(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2-8-79, to 2-9-79, that (I) (we) last saw the deceased alive on 2-9-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
H.A. Molavi, M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		2-9-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
H.A. Molavi, M.D.		ECF P.G. Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		2-14-79		HARMONY CEM		HANDOVER MD	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D BY REGISTRAR			
WATSON F. H.		3435 14TH ST. N.W.		25b. REGISTRAR'S SIGNATURE			



9-02024

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-05025	
1. FOR STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDNA E. STEBBINS						2a. DATE OF DEATH MONTH DAY YEAR 02-18-79		2b. HOUR 1:50AM	
3. SEX F		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 7/6/06		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.					
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY None			
13a. STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Forrestville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2210 Ritchie Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST Hobart Soper				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Matildia Schickler							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-26-9376A		17. INFORMANT ADDRESS Carol Jones 5510 Vernon Way Camp Springs Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Occlusion 4349 DUE TO, OR AS A CONSEQUENCE OF (b) } (c) } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 Hr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 16 Feb 1979, to 18 Feb 1979, that (I) (we) last saw the deceased alive on 16 Feb 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE Seth H. Lourie MD				DEGREE MD				22c. DATE SIGNED 18 Feb 79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Seth H. Lourie				22e. ADDRESS 5806 Baltimore Av, Hyattsville 20781 MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/23/79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery Suitland P.G. Md.				23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Lee Funeral Home Inc. 6635 Old Alexander Ferry Rd. Clinton, Md.				25a. DATE REC'D. BY REGISTRAR Feb 21 1979				25b. REGISTRAR'S SIGNATURE			

78-02022

Wash. D.C.	U.S.A.	x	7/1/00	72
Housewife	Housewife	x	Housewife	Housewife
Robert Roper	Robert Roper	x	Robert Roper	Robert Roper
218-28-0276A	218-28-0276A	x	218-28-0276A	218-28-0276A
Springfield	Springfield	x	Springfield	Springfield

6633 Old Alexander Ferry Rd. Clinton, Md.  
21231/70, Cedar Hill Cemetery, Baltimore, Md.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79-05026

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		2b. HOUR	
Martha		K.				Stephen		2		3		19		79				M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
female	white	Aug 31 53		25 YRS.						2		4		19		79		2:25 a.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH											
Washington D.C.		U S A		WIDOWED		DIVORCED		Prince George County										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Cheverly		Prince George General Hospital		Technician		Medical													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Maryland		Pr Geo		TempleHills		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3239 Beaumont Street											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
Earlie		Burgess		Irass		Parent													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No		217 60 7508		Robert W. Stephen (Hus)		Same as #13													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Acute methadone intoxication															
3040		DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		(b)		DUE TO, OR AS A CONSEQUENCE OF															
		(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED															
Margarita A. Korell, M.D.		Assistant		2/5/79															
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS																	
Margarita A. Korell, M.D.		111 Penn Street, Balto., MD 21201																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE													
Burial		7Feb1979		Resurrection Cem.		Clinton PG Md													
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
Robert E. Wilhelm Funeral Home		FEB 13 1979		[Signature]															
Suitland, Md.																			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-05027	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARGARET A. STUBBS</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>02-07-79</b>			2b. HOUR <b>3PM</b>		M	
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 20, 1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55 years</b>		IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		IF UNDER 24 HRS. HOURS MIN. <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Iowa</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S COUNTY MD.</b>					
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGE'S HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U S Government</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6807 Fairwood Road</b>				
13a. STATE <b>Md</b>		13b. COUNTY <b>Pro Georges</b>		13c. CITY OR TOWN <b>Hyattsville</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>Eugene Engel</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helena J Quinlan</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>478 20 9272</b>		17. INFORMANT <b>Snoden A Stubbs</b>				ADDRESS <b>Hyattsville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRAIN Stem Compression</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>METASTATIC CANCER TO BRAIN</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>LUNG CARCINOMA</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>2/4</b> 19 <b>77</b> , to <b>2/7</b> 19 <b>77</b> , that (I) (we) lost saw the deceased alive on <b>2/7</b> 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>William R. Leahy MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>2/7/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WILLIAM R. LEAHY MD</b>				22e. ADDRESS <b>6201 GREENBELT Rd. Colver PK 2700</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb 10, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Springs Montgomery Md</b>					
24. FUNERAL DIRECTOR NAME <b>F. Gasch's Sons P A Hyattsville, Md</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 13 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony M. Brady</b>			



13-02021

67-50-20

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DATE: 12/19/91

POLICE DEPARTMENT, HOSPITAL

CHEMISTRY

1. The first group of people who are not in the labor force are those who are not in the labor force because they are not in the labor force.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-05028

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CORA E. SULLIVAN			2a. DATE OF DEATH MONTH DAY YEAR 02-13-79		2b. HOUR 8.30 P.M.								
3 SEX F		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 3, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.							
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY home					
13a. STATE Md						13b. COUNTY Howard		13c. CITY OR TOWN Fulton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8212 Reservoir Road	
14. FATHER'S NAME FIRST MIDDLE LAST Horace Wesley Souder				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susanna A. Giddings									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218 14 7272		17. INFORMANT ADDRESS Patsy Scaggs same as above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gram negative bacteremia</u> 0384 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus, Parkinsonism, Arteriosclerotic cardiovascular disease</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I) OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>1970</u> , 19 <u>79</u> , to <u>2-13</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>2-13</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Fred C Cristofori</u> 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Fred C CRISTOFORI</u>				DEGREE <u>MD</u> 22e. ADDRESS <u>3327 Superior Lane, Bowie, Md 20715</u>				22c. DATE SIGNED <u>2/14/79</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 16, 1979		23c. NAME OF CEMETERY OR CREMATORY Emmanuel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Scaggsville, Md							
24. FUNERAL DIRECTOR NAME <u>Donald H. JH</u> ADDRESS <u>Chesapeake, Md</u>						25a. DATE REC'D. BY REGISTRAR MAR 5 1979		25b. REGISTRAR'S SIGNATURE <u>Robert A. Brady</u>					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

85020-05

FAST LITE

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH79-05029  
REG. NO.

1. FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) <b>VIVIAN Marguerite Sullivan</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>02 21 79</b>		2b. HOUR <b>5:12P.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>08 07 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60 62</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD.	
10. CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTHERN MARYLAND HOSPITAL CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Waitress</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Food Service</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>Oxon Hill</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Franklin Pierce</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Edith Pierce</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>579-34-8923</b>	
17. INFORMANT ADDRESS <b>Douglas M. Sullivan same as 13</b>		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cirrhosis of Liver</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>5715</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 mos</b> <b>3 yrs</b>		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Incarcerated in bitical hernia</b>	
19a. DATE OF OPERATION <b>1-20-79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Incarcerated hernia</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>1975</b> to <b>2-21-79</b> , that (I) (we) last saw the deceased alive on <b>2-21-79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <b>Daniel Howell</b> M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED <b>2-22-79</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Daniel Howell, M.D.</b>		22e. ADDRESS <b>Waldorf, Maryland 20601</b>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	
23b. DATE <b>2-26-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Colmar Manor, P.G., MD.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Huntt Funeral Home Waldorf, Maryland</b>	
25a. DATE REC'D. BY REGISTRAR <b>MAR 5 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony M. Brady</b>		25c. REGISTRAR'S NAME <b>Anthony M. Brady</b>		25d. REGISTRAR'S ADDRESS <b>Anthony M. Brady</b>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-05030

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	M.			
DALE		RUSSELL		SUTHERLAND	02	01	79		1:50P.	M.			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 74 HRS.					
Male	Caucasian	02 18 27		51		MONTHS		DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Kentucky	USA			Prince Georges						MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
Clinton	SOUTHERN MARYLAND HOSPITAL CENTER		Construction										
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. CITY OR TOWN		13b. STREET ADDRESS									
13a. STATE		13b. COUNTY		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS							
Md.		Pr. Geo.		Clinton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		10945 Piscataway Rd.					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST		FIRST MIDDLE LAST											
Clifford		Sutherland		Burl		Anderson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS							
Yes		W.W.II		578 30 2924		Celie Sutherland, Wife, Same as Above							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MALIGNANT LYMPHOMA, DIFFUSE HISTIOCYTIC TYPE</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>16 MONTHS</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____		

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <u>did not</u> attend the deceased from <u>1/8</u> 19 <u>77</u> , to <u>2/1</u> 19 <u>77</u> , that <u>we</u> lost saw the deceased alive on <u>1/8</u> 19 <u>77</u> , and that in <u>(a)</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>(we)</u> <u>did not</u> view the body after death.					

22b. SIGNATURE <u>James G. Brown MD</u>		DEGREE	22c. DATE SIGNED <u>2/1/79</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JAMES A. BROWN MD</u>		22e. ADDRESS <u>625 BELLEST RD HYATTSVILLE, MD. 20782</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	2-3-79	Wash. Natl. Cem.	Suitland, P.G., Maryland
24. FUNERAL DIRECTOR NAME Robt E Wilhelm		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <u>Rafael McCreedy</u>
Funeral Home Rd., Suitland, Md.		FEB 8 1979	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in person.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-05031 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERTHA V. SWEENEY										2a. DATE OF DEATH MONTH DAY YEAR 02 13 79		2b. HOUR 06:30P M	
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 8 1 1899		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY, MD.							
10 CITY OR TOWN OF DEATH RIVERDALE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) EUGENE LELAND MEMORIAL HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.				13b COUNTY Pr.Geo.		13c CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7713 - Frederick Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST Philip				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Farnan									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17 INFORMANT ADDRESS Mrs. Nancy J. Khan - above address							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, Rt. lung</u> 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <u>Electrolyte imbalance</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CVA with Lt. hemiplegia</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Decubitus ulcers, severe. Hypoalbuminemia. Anemia</u>													
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>12/12</u> , 19 <u>78</u> , to <u>2/13</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>2/13/79</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>2LK Don. MD.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>2/14/79</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>YEAR-KWON H. YOON</u>				22e ADDRESS <u>5506 Kendworth Ave. Riverdale, Md.</u>									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/16/1979		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.							
24 FUNERAL DIRECTOR NAME Nalley's F.H. Inc.				ADDRESS Mt. Rainier, Md.		25a. DATE REC'D. BY REGISTRAR FEB 21 1979		25b. REGISTRAR'S SIGNATURE <u>Pitney McCreedy</u>					



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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-05032

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>IDA Francis TAYLOR</b>			2a. DATE OF DEATH MONTH <b>02</b> DAY <b>01</b> YEAR <b>79</b>			2b. HOUR <b>7:57 A.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH <b>08</b> DAY <b>25</b> YEAR <b>81</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>97</b> YRS		7. IF UNDER 1 YEAR MONTHS <b>00</b> DAYS <b>00</b> HOURS <b>00</b> MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wisconsin</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD.			
10. CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTHERN MARYLAND HOSPITAL CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>Md.</b>			13b. COUNTY <b>Pr. Geo.</b>		13c. CITY OR TOWN <b>Clinton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST <b>Rush</b> MIDDLE <b>Francis</b> LAST <b>Clinton</b>			15. MOTHER'S MAIDEN NAME FIRST <b>unavailable</b> MIDDLE <b>unavailable</b> LAST <b>unavailable</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>-----</b>			17. INFORMANT ADDRESS <b>Mrs. Enid I. Schaeffer same as 13</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CVA, CHF, Renal failure.</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cardiac arrhythmias.</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 DAYS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Cardiac arrhythmias.</b>									
19a. DATE OF OPERATION <b>---</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>---</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR <b>---</b> A.M. MONTH <b>---</b> DAY <b>---</b> YEAR <b>19</b> P.M.			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <b>---</b> CITY OR TOWN <b>---</b> COUNTY <b>---</b> STATE <b>---</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>1-19, 1979</b> to <b>2-1-1979</b> , that (I) (we) last saw the deceased alive on <b>1-31-1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>EMMA TI</b>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2-1-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. NEMAT, M.D. / R. MOSTAAN, M.D.</b>			22e. ADDRESS <b>4235 28th Avenue, Marlow Hgts, MD 20031</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>2-3-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Mem. Garden Waldorf, Charles, Md.</b>		23d. LOCATION CITY OR TOWN <b>---</b> COUNTY <b>---</b> STATE <b>---</b>		
24. FUNERAL DIRECTOR NAME <b>Huntt Funeral Home Waldorf, Maryland</b>			ADDRESS <b>---</b>			25a. DATE REC'D. BY REGISTRAR <b>FEB 7 1979</b>		25b. REGISTRAR'S SIGNATURE <b>History McCreedy</b>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 79-05033	
1. FOR STATE REGISTRAR					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lillian May Taylor			2a. DATE OF DEATH MONTH DAY YEAR February 28 1979		2b. HOUR 4 <sup>30</sup> P.M.
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR February 2 1882		6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.	
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Magnolia Gardens Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical Sect.	12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
13a. STATE Md.			13b. COUNTY Mont.	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST James William Taylor			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Almyra Vasburgh		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. n/a		17. INFORMANT ADDRESS Dorothy Taylor Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from September 20, 1976, to February 28, 1979, that (I) (we) lost saw the deceased alive on February 27, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Leon Levitsky, M.D.		DEGREE M.D.		22c. DATE SIGNED 2/28/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Leon Levitsky, M.D.		22e. ADDRESS Magnolia Gardens Nursing Home			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3 MAR 79		23c. NAME OF CEMETERY OR CREMATORY Chestnut Grove Cem	
23d. LOCATION CITY OR TOWN Herndon, Virginia		23e. COUNTY			
24. FUNERAL DIRECTOR NAME Robert G. Beall		24b. FUNERAL HOME ADDRESS 9013 Annapolis Rd. Lanham, Md. 20801		25a. DATE REC'D BY REGISTRAR MAR 5 1979	
25b. REGISTRAR'S SIGNATURE Anthony M. Brady					

93-02033

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

100-443888-100

TO : DIRECTOR, FBI (100-443888-100)  
FROM : SAC, NEW YORK (100-100000) (P)  
SUBJECT: [Illegible]  
RE: [Illegible]  
[Illegible text follows]

[Illegible text follows]

[Illegible text follows]

100-443888-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-05034	
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JACOB H THOMPSON</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>2 2 79</b>			7b. HOUR <b>11:30AM</b>			
3 SEX <b>Male</b>		4 RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 3 48</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>30</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S COUNTY MD.</b>					
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGE'S GEN HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <b>Maryland District Heights</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>7015 Gateway Boulevard</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jacob H. Thompson</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Evelyn Harley</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>577 64 8038</b>		17. INFORMANT ADDRESS <b>7015 Gateway Blvd. Juanita Thompson-wife</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Annual Seizure Disability</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>1-28</b> , 19 <b>79</b> , to <b>2-2</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>2-2</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Joseph Colonna MD.</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/2/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joseph Colonna MD.</b>						22e. ADDRESS <b>PGBH &amp; MC. Cheverly MD 20785</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/7/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Stewart Funeral Home-4001 Benning Road, NE.</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 8 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

99

2301 BP



19-02034

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [illegible]  
RE: [illegible]

On [illegible] at [illegible]  
[illegible] [illegible] [illegible]

Very truly yours,  
[illegible]  
Special Agent in Charge

Enclosed for the Bureau are [illegible]  
[illegible] [illegible] [illegible]

[illegible]  
[illegible] [illegible] [illegible]

Very truly yours,  
[illegible]  
Special Agent in Charge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-05035 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EMORY N. THRIFT</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>02-07-79</b>			2b. HOUR <b>3:50A M</b>		
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec 9, 1903</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S COUNTY MD</b>					
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGE'S GEN. HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cabinet Maker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>US. Gov't</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <b>Maryland Pr. Geo's Hyattsville</b>						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3604 Longfellow Street</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John R. Thrift</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha ?</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>216-44-9241</b>		17. INFORMANT ADDRESS <b>Mary A. Thrift (wife) same as above</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemic Shock</b> <b>5184</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Pulmonary Edema &amp; Congestion</b> (c) <b>Due to, or as a consequence of</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>1-3-79</b> , 19 <b>79</b> , to <b>2-7</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>2-7</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <i>Joseph Collette MD</i> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <b>2/8/79</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joseph Collette MD</b>						22e. ADDRESS <b>P. O. Box 4</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Feb 9, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood Pr. Geo's Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Francis Gasch's Sons, PA Hyattsville, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 15 1979</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Brady</i>			

BP

Mr. Lee's Hyattsville 2001 Washington Street x 2001 Washington Street

John E. Smith  
Martha E. Smith  
?

215-44-3241 (NY) .A. (Bill) (wife) same as above

Acute Pulmonary Edema & Congestion

1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 26

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 79-05036			
1. DECEASED NAME (TYPE OR PRINT) <i>Andrew Michael Tilghman</i>						2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/> 2-12 1979		2b. HOUR M 25					
3. SEX <i>Male</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH <i>12</i> DAY <i>10</i> YEAR <i>1908</i>	6. AGE (IN YEARS) LAST BIRTHDAY <i>70</i> YRS.	IF UNDER 1 YR. MONTHS <i>0</i> DAYS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i> MIN. <i>0</i>	2c. DATE PRONOUNCED DEAD MONTH <i>2</i> DAY <i>12</i> YEAR <i>1979</i>		2d. HOUR M 25					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD.							
10. CITY OR TOWN OF DEATH <i>District Hgts.</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>2015 County RD.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Safeway</i>					
13a. STATE <i>Md.</i> 13b. COUNTY <i>P.G.</i> 13c. CITY OR TOWN <i>Dist. Hgts.</i>										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>2015 County Rd.</i>	
14. FATHER'S NAME FIRST <i>William</i> MIDDLE <i>Tilghman</i> LAST <i>Tilghman</i>						15. MOTHER'S MAIDEN NAME FIRST <i>Alice</i> MIDDLE <i>(Unknown)</i> LAST <i>(Unknown)</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>579-01-1807</i>		17. INFORMANT ADDRESS <i>Marilyn Hamilton-6701 Atwood St.</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Coronary atherosclerosis and myocardial infarction</i> <i>4292</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) <i>M.D. Deputy</i>				MEDICAL EXAMINER DATE SIGNED <i>2-12-79</i>					
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez</i>				ADDRESS <i>12800 W. 11th Ave, Parkville, Mo 64116</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>2-16-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Harmony Mem. Cem.</i>				23d. LOCATION CITY OR TOWN <i>Highland Park</i> COUNTY <i>Md</i> STATE <i>Mo</i>					
24. FUNERAL DIRECTOR NAME <i>H.S. Washington &amp; Sons</i> ADDRESS <i>4925 Burroughs Ave,</i>						25a. DATE REC'D. BY REGISTRAR <i>FEB 16 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Maryanne Brady</i>					

10-02030

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					79-05037 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DORIS B. TIMBS					2a. DATE OF DEATH MONTH DAY YEAR 02 14 79			2b. HOUR P M 6:28 P M	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12-4-1906		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Housekeeper		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE -		13b. COUNTY -		13c. CITY OR TOWN Wash., D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3104 - Adams St., N.E.	
14. FATHER'S NAME FIRST MIDDLE LAST Middleton Luber					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Doretta Benesce				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) -			16b. SOCIAL SECURITY NO. 577-56-8159		17. INFORMANT ADDRESS 5-Green Tree Pl. Greenbelt, Md.			17. INFORMANT Ronald L. Timbs	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>scleroderma</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>65</u> , to <u>FEB 14</u> , 19 <u>79</u> , that (I) <u>was</u> last saw the deceased alive on <u>FEB 14</u> , 19 <u>79</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>was</u> (did) (did not) view the body after death.									
22b. SIGNATURE <u>Don B. Cameron</u> MD					DEGREE MD			22c. DATE SIGNED 2-16-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DON B. CAMERON					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 2-20-79		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory			23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.	
24. FUNERAL DIRECTOR NAME Valley's F.H. Inc.					24b. ADDRESS Mt. Rainier, Md.		25. DATE RECEIVED BY REGISTRAR FEB 20 1979		
25b. REGISTRAR'S SIGNATURE <u>Anthony Delaney</u>									

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72-02031



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REC. NO. 79-05038			
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST JAMES ANDREW TURNER Sr.		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH DAY YEAR 2-24 19 79		2b. HOUR M A		
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5-7-01		6. AGE (IN YEARS) (LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2-25 19 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.			
10. CITY OR TOWN OF DEATH Andrews AFB				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow USAF Hospital (DOA)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland				13b. COUNTY Pr. George's		13c. CITY OR TOWN Upper Marlboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9319 D'Arcy Road			
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Turner (D)				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Carroll (D)									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 579-12-4549		17. INFORMANT ADDRESS Lottie L. Turner (W) Same as Item #13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Diabetes Mellitus</u>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER		DATE SIGNED 2/26/79			
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez				12800 Willow Wind Circle, Oxon Hill, Md 20022									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE March 1, 1979		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, PG Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS Hollins Funeral Home, Inc. 4339 Hunt Pl. N.E.						25a. DATE REC'D. BY REGISTRAR 1979		25b. REGISTRAR'S SIGNATURE <i>Robert McKeedy</i>					



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>2/7/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	23d. LOCATION CITY OR TOWN <b>Brentwood, P.G., Maryland</b>
24. FUNERAL DIRECTOR NAME <b>Lee Funeral Home, Clinton, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 13 1979</b>	25b. REGISTRAR'S SIGNATURE <i>Anthony J. Brady</i>

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11-17-78</u> , 19 <u>  </u> , to <u>2-3</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>  </u> 19 <u>  </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>William Kent Furst</i>		22c. DATE SIGNED <b>2/3/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William Kent Furst</b>		22e. ADDRESS <b>Regency Nursing Home, Forestville, Md</b>	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>	16b. SOCIAL SECURITY NO. <b>281-12-1476-A</b>	17. INFORMANT <b>Lillian Venneri, same as 13 a-e</b>
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14. FATHER'S NAME FIRST <b>Gebriel</b> MIDDLE <del>XXXXXXXX</del> LAST <b>Venneri</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Frances</b> MIDDLE <b>Altomare</b> LAST <b>Altomare</b>
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13a. STATE <b>md.</b>	13b. COUNTY <b>P.G.</b>	13c. CITY OR TOWN <b>Clinton</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>3303 Accolada Dr.</b>
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12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Contractor</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>
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10. CITY OR TOWN OF DEATH <b>Forestville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Regency</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Contractor</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>
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7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>	7b. CITIZEN OF WHAT COUNTRY? <b>US Nat.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD.
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1. DECEASED NAME (TYPE OR PRINT) FIRST <b>Joseph</b> MIDDLE <b>G.</b> LAST <b>Venneri Sr.</b>	2a. DATE OF DEATH MONTH DAY YEAR <b>2-3-79</b>	2b. HOUR <b>9:35<sup>PM</sup></b>
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3. SEX <b>M</b>	4. RACE <b>Cau.</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 29, 1902</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATHREG. NO. **79-05039**1. FOR  
STATE  
REGISTRAR

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-05040	
1. FOR REGISTERAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIOLA WADE					2a. DATE OF DEATH MONTH DAY YEAR 02-01-79			2b. HOUR 6:31 AM			
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR Sept. 19, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Florida		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.					
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none		12b. KIND OF BUSINESS OR INDUSTRY none			
13a. STATE Maryland		13b. COUNTY Pri. Geo.		13c. CITY OR TOWN New Carrollton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME FIRST MIDDLE LAST Edward Payton		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (Unknown)				13e. STREET ADDRESS 7723 Riverdale Road, Apt. 102					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT ADDRESS New Carrollton, Alphonso Wade, Jr., 7723 Riverdale Rd., Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 5609 } DUE TO, OR AS A CONSEQUENCE OF b) Respiratory failure, renal failure c) } DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Mechanical small bowel obstruction									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION 1.25.79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bowel obstruction				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from 1-15, 1979, to 2-1, 1979, that (we) last saw the deceased alive on 2-1, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Haluk Boneval MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2.1.79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Haluk Boneval, M.D.				22e. ADDRESS 6001 Laddover Rd., Cheverly, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Feb. 2, 1979		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia					
24. FUNERAL DIRECTOR Robert G. Beall Lanham Funeral Home 9013 Annapolis Road, Lanham, Maryland				25a. DATE REC'D BY REGISTRAR FEB 5 1979		25b. REGISTRAR'S SIGNATURE [Signature]					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-05041	
1. FOR STATE REGISTRAR					2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		
1 DECEASED NAME (TYPE OR PRINT) WILLIAM WALKER					02-23-79		6:30 P.M.				
3 SEX Male		4 RACE Negro		5 DATE OF BIRTH MONTH DAY YEAR 06 13 1906		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.					
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook		12b. KIND OF BUSINESS OR INDUSTRY Restaurant			
13a. STATE Maryland					13b. COUNTY Prince Geo		13c. CITY OR TOWN Chapel Oak		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 578 03 6674		17 INFORMANT Florence Walker-Wife		ADDRESS					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC Arrest 2500 } DUE TO, OR AS A CONSEQUENCE OF (b) possible Myocardial infarction (c) Diabetic Mellitus 20 years PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic Renal Failure 2+ Diabetic Mellitus										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hours	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 2/22 19 79, to 2/23 19 79, that (I) (we) last saw the deceased alive on 2/23 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (it) (did not) view the body after death.											
22b. SIGNATURE Dr. Pollak		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/24/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steven Pollak M.D.		22e. ADDRESS 4700 AUTH PLACE CAMP SPRINGS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 02/28/79		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Landover, PG Maryland					
24 FUNERAL DIRECTOR NAME ALEXANDER S. POPE				ADDRESS 2617 Pennsylvania Ave., S.E.				25a. DATE REC'D. BY REGISTRAR 2/28/79			
								25b. REGISTRAR'S SIGNATURE			

0000 BP



Postal 02/25/79 Brynony Memorial Park Langover, MD Maryland

sys of 10/14 Florence Walker-Wife

Maryland Prince Georges Capitol City X 2101 Quef Place  
CHEVERLY PRINCE GEORGES GENERAL HOSPITAL Roof Freestanding  
South Carolina United States  
Male 1930 02 13 1908 TS

WILLIAM WALKER

02-23-79

19-02041



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
REG. NO. 79-05042									
1. DECEASED NAME (TYPE OR PRINT) EDNA T WALL					2a. DATE OF DEATH MONTH 2 DAY 3 YEAR 79		2b. HOUR 2:50P M		
3 SEX Female		4 RACE White		5 DATE OF BIRTH Sept 29, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 76		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GEN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Officer		12b. KIND OF BUSINESS OR INDUSTRY Army	
13a. STATE Maryland		13b. COUNTY Prince Geo		13c. CITY OR TOWN Landover		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3318 Dodge Park Road	
14. FATHER'S NAME FIRST MIDDLE LAST Webster Thompson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Higdon				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) .226 48 0627		17. INFORMANT ADDRESS Anna Webb Hyattsville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DEHYDRATION &amp; MAL NUTRITION</u> <u>2639</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>ANOREXIA NERVOSA</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>2 mo</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. certify that (I) (this hospital) attended the deceased from <u>1-27</u> 19 <u>79</u> , to <u>2</u> 3 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>2-3</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <u>Roger B Ingham</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <u>2/4/79</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Roger. Ingham MD</u>						22e. ADDRESS <u>Hyattsville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Feb 7, 1979</u>		23c. NAME OF CEMETERY OR CREMATORY <u>West View Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Atlanta Fulton Georgia</u>			
24. FUNERAL DIRECTOR NAME <u>F. Gasch's Sons P A</u> ADDRESS <u>Hyattsville, Md.</u>						25a. DATE REC'D. BY REGISTRAR <u>FEB 7 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Anthony McCready</u>	

78-02043

CHURCHILL

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PRINCE GEORGE'S COUNTY

PRINCE GEORGE'S GEN HOSPITAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-05043

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
PEARL		E.		WASHINGTON		02-03-79 9PM M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
F	B	12-15-1910		68		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MO.	U.S.A.			PRINCE GEORGE'S COUNTY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
CHEVERLY	EXTENDED CARE FACILITY			HOUSEWIFE		HOME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS			
MO.	P.G.	SEAT Pleasant	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1144 BOOKER DR.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
JOHN		LAURA					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
No		220-12-4089		JAMES WASHINGTON - SAME AS #13 ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lipomyosarcoma of uterus</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2-2-79</u> to <u>2-3-79</u> , that (I) (we) lost saw the deceased alive on <u>2-3-79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>H. A. Molavi, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-5-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>H. A. MOLAVI, M.D.</u>				22e. ADDRESS <u>6005 Landover Rd Cheverly, Md</u>			
23a. BURIAL CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
		2-8-79		FT. LINCOLN CEM.		BLADENSBURG MD.	
24. FUNERAL DIRECTOR NAME <u>H. S. WASHINGTON + SONS 4925 BURROUGHS AVE. N.E.</u>				25a. DATE REC'D. BY REGISTRAR <u>FEB 8, 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Mary McCreedy</u>	

78-02043

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

WASHINGTON, D. C. 20535

PRINCE GEORGE'S COUNTY

EXTENDED CARE FACILITY

OVERVIEW

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. <b>79-05044</b>	
1. DECEASED NAME (TYPE OR PRINT) <b>Dorothy Eleanor WATKINS</b>										2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> <b>2-7 1979</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>5</b> DAY <b>15</b> YEAR <b>18</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>60</b> YRS.	IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD MONTH <b>2</b> DAY <b>7</b> YEAR <b>1979</b>		2d. HOUR <b>1:30</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Va</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES</b>					
10. CITY OR TOWN OF DEATH <b>New Carrollton</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <b>7605 Vicar St.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a. STATE <b>Md.</b>		13b. CITY OR TOWN <b>New Carrollton</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>7605 Vicar Street</b>					
14. FATHER'S NAME FIRST <b>Unknown</b> MIDDLE <b></b> LAST <b></b>				15. MOTHER'S MAIDEN NAME FIRST <b>Sally</b> MIDDLE <b>Croston</b> LAST <b></b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>234 32 7670</b>		17. INFORMANT ADDRESS <b>Gary Cooper New Carrollton Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE <b>Arteriosclerotic cardiovascular disease</b> <b>4392</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Chronic obstructive pulmonary disease</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>				TITLE (SPECIFY) <b>DEPUTY</b>				MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT) <b>AUGUSTO P. RODRIGUEZ</b>				ADDRESS <b>12800 WILLOW WIND CIRCLE, TANTALLON, MD</b>				DATE SIGNED <b>2-7-79</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Feb 10, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Maplewood Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Kingwood</b> COUNTY <b>Preston</b> STATE <b>West Va</b>			
24. FUNERAL DIRECTOR NAME <b>F. Gasch's Sons P A</b> ADDRESS <b>Hyattsville, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 15 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

DHMH - 17  
(VR A15 ME (5))  
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19-02044

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79-05045	
1. FOR STATE REGISTRAR 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>BERNICE W. WILLET</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>2 11 79</b>		2b. HOUR <b>2:55AM</b>			
SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 11 1890</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Indiana</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b> MD.					
10. CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Maryland Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD.</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Upper Marlboro</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5436 Old Crain Highway</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Wilson</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Ann Armstrong</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>216-12-4249</b>		17. INFORMANT ADDRESS <b>Hillside, Md. Lillian Schultz, 924 Mentor Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>gangrene of left lower leg</b> <b>4140</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>severe peripheral arterial occlusive disease</b> (c) <b>atherosclerotic coronary heart disease</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>weeks</b> <b>years</b> <b>years</b>			
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>left basilar pneumonia &amp; pleurisy, cerebro-vascular insufficiency</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 21</b> , 19 <b>58</b> , to <b>Feb 11</b> , 19 <b>59</b> , that (I) (we) last saw the deceased alive on <b>Feb 11</b> , 19 <b>59</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Peter W. Jim M.D.</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>Feb. 11 59</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PETER W. JIM M.D.</b>				22e. ADDRESS <b>7900 Old Branch Ave, Clinton Maryland 20735</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2-14-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, P.G., Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Robt E Wilhelm</b>				ADDRESS <b>4308 Suitland Rd., Suitland, Md.</b>		25. DATE REC'D. BY REGISTRAR <b>FEB 22 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert E. Wilhelm</b>			

18-02012

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10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 39-05046			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN W. WILLIAMS										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 2-23 1979		2b. HOUR M 5:04	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 4-2-21		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.			
10. CITY OR TOWN OF DEATH CHEVERLY				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GEN. HOSP.(DOA)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bus Driver		12b. KIND OF BUSINESS OR INDUSTRY Metro			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND										13b. COUNTY PRINCE GEORGES		13c. CITY OR TOWN LANDOVER	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS 2306 VERMONT AVENUE			
14. FATHER'S NAME FIRST MIDDLE LAST Unknown					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Estelle ?								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 247 03 9454		17. INFORMANT ADDRESS Frances Williams(Same as decedent)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Augusto P. Rodriguez				TITLE (SPECIFY) DEPUTY MEDICAL EXAMINER				DATE SIGNED 2-23-79					
EXAMINER'S NAME (TYPE OR PRINT) AUGUSTO P. RODRIGUEZ, M.D.				ADDRESS 12800 WILLOW WIND CIRCLE TANTALLON MD. 20022									
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) Burial				23b. DATE 2/28/78		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Md.					
24. FUNERAL DIRECTOR NAME Robert G. Mason, Inc.,						ADDRESS Washington, D.C.		25a. DATE REC'D. BY REGISTRAR FEB 28 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

64020-25

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME, OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))  
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 89-05047	
1. DECEASED NAME (TYPE OR PRINT) <b>Welford WILLIS</b>										2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>2-10-79</b>	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH (MONTH DAY YEAR) <b>4-15-22</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD <b>2-10-79</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>✓</b>				7b. CITIZEN OF WHAT COUNTRY? <b>✓</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES</b> MD.	
10. CITY OR TOWN OF DEATH <b>Chesley</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince Georges Hospital (DOA)</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE <b>Maryland</b> COUNTY <b>Prince Georges</b> CITY OR TOWN <b>Coral Hills</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1226 Benning Road</b>	
14. FATHER'S NAME (FIRST MIDDLE LAST) <b>Eugene Willis</b>						15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Minnie Lewis</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>				16b. SOCIAL SECURITY NO. <b>577-28-4554</b>		17. INFORMANT ADDRESS <b>Dwight Willis/son 901 N.J. Ave. N.W. Washington, D. C.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular disease</b> 429.2 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY (HOUR A.M. MONTH DAY YEAR) P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION (STREET CITY OR TOWN COUNTY STATE)					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>				TITLE (SPECIFY) <b>DEPUTY</b> M.D.				MEDICAL EXAMINER DATE SIGNED <b>2-10-79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>AUGUSTO P. RODRIGUEZ</b>				ADDRESS <b>M.D. 12800 WILLOW WIND CIRCLE TANTALLON, MD 20022</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>2-16-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>First Baptist Cemetery</b>				23d. LOCATION (CITY OR TOWN COUNTY STATE) <b>Louisa, Virginia</b>	
24. FUNERAL DIRECTOR NAME <b>Thomasson's Funeral Home</b> ADDRESS <b>PO Box 512 Louisa Virginia</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 28 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

19-02001



19-02001

19-02001



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for autops.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-05048	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST REBECCA V. WINDLE						2a. DATE OF DEATH MONTH DAY YEAR 02-08-79				2b. HOUR 6:25PM M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 9, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.					
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Reg. Nurse		12b. KIND OF BUSINESS OR INDUSTRY Pr. Geo County Gvmnt			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.						13b. COUNTY Pr. Geo's		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Harry -- Witter						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Virginia Miller					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. --		17. INFORMANT ADDRESS 15405 Hall Rd., Garrett L. Windle-Bowie, Md. 20716					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1749 MENINGEAL CARCINOMATOSIS DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma, Right breast DUE TO, OR AS A CONSEQUENCE OF (c) 4 yrs. ago										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 mo. ago	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) HYPOTHYROIDISM; DIABETES MELLITUS; ATRIAL FIBRILLATION											
19a. DATE OF OPERATION 1/25/79				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED HYDROCEALUS				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NO				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1978 to 2/8/79, that (I) (we) last saw the deceased alive on 2/8/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE C. Soriano						DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/9/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CESAR SORIANO JR.						22e. ADDRESS 119 Capitol Heights Blvd., Capitol Heights, Md. 20027					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2/12/79		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Frederick Md.	
24. FUNERAL DIRECTOR Richard A. Coleman-Upper Marlboro, Funeral Home Maryland 20870						25a. DATE REC'D. BY REGISTRAR MAR 6 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79-05049

1. FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>DAVID PAUL WITTER.</b>			2a DATE OF DEATH MONTH <b>2</b> DAY <b>13</b> YEAR <b>79</b>			2b HOUR <b>3:24 p.m.</b>					
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH <b>July</b> DAY <b>1</b> YEAR <b>1905</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS		7 IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		8 IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>	
9a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		9b CITIZEN OF WHAT COUNTRY? <b>USA</b>		10 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b> MD.					
10 CITY OR TOWN OF DEATH <b>Riverdale</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SINGLE CITY, GIVE STREET ADDRESS) <b>Leland Memorial Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk Ret.</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Univ. of Md.</b>			
13a STATE <b>Maryland</b>			13b COUNTY <b>Pr. Geo's</b>		13c CITY OR TOWN <b>Univ. Park</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>4327 Van Buren Street</b>		
14 FATHER'S NAME FIRST <b>David</b> MIDDLE <b>J.</b> LAST <b>Witter</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Minerva</b> MIDDLE <b>A.</b> LAST <b>Loats</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>WWII</b>			17 INFORMANT <b>Mrs. Delvin S. Witter (sis-in-law)</b>			ADDRESS <b>San Ant. Texas</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <b>Undeterm.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b>											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>None</b>											
19a DATE OF OPERATION <b>N/A</b>			19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSE OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>			21b. TIME OF INJURY HOUR <b></b> A.M. <b></b> MONTH <b></b> DAY <b></b> YEAR <b>19</b> P.M. <b></b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>N/A</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> <b>N/A</b>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>N/A</b>			21f. LOCATION STREET <b>N/A</b>			CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>		
22a. I certify that (I) (this hospital) attended the deceased from <b>7/18</b> , 19 <b>75</b> to <b>Feb 13</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>Jan 22</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <b>William F. Simpson, MD</b>						DEGREE <b>MD</b>			22c. DATE SIGNED <b>2/13/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William F. Simpson, MD</b>						22e. ADDRESS <b>8706 N Han Silver Spring Rd 20903</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>2/17/79</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Kriders Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Westminister Carroll, Md.</b> COUNTY <b></b> STATE <b></b>		
24 FUNERAL DIRECTOR NAME <b>Francis Gasch's Sons, PA, Hyattsville, Md.</b> ADDRESS <b></b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 23 1979</b>			25b. REGISTRAR'S SIGNATURE <b>Marking McCready</b>		

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

3606

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DHMH - 16 60M 1/75  
(VRA 15 (4))

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-05050	
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) PAUL B WOOSTER					2a. DATE OF DEATH MONTH DAY YEAR 2 21 79				2b. HOUR 7:15A M		
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 1 7 1907		6. AGE (IN YEARS LAST BIRTHDAY) 72		7. IF UNDER YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.					
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GEN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Painter-Self-employed		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.			13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Beltsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 512-Cypress Rd.		
14. FATHER'S NAME FIRST MIDDLE LAST Walter Wooster					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Onthank						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 219-01-2126		17. INFORMANT Hazel M. Wooster, above address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure, pulmonary edema (Wife) DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Chronic obstructive pulmonary Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from February 13, 1979, to February 21, 1979, that (I) (we) last saw the deceased alive on February 21, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE CHIN-CHUAN HSU					DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-21-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHIN-CHUAN HSU					22e. ADDRESS 6905 Baltimore Blvd College Park Md 20740						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/23/1979		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.			
24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc.					ADDRESS Mt. Rainier, Md.		25a. DATE REC'D. BY REGISTRAR FEB 23 1979		25b. REGISTRAR'S SIGNATURE		

TO : DIRECTOR, FBI (100-441111) FROM : SAC, NEW YORK (100-100000) (P)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

FOR THE DIRECTOR: [Illegible]

FOR THE SAC: [Illegible]

FOR THE ASAC: [Illegible]

FOR THE CLERK: [Illegible]

FOR THE CHIEF OF POLICE: [Illegible]

FOR THE CHIEF OF FIRE: [Illegible]

FOR THE CHIEF OF HEALTH: [Illegible]

FOR THE CHIEF OF SOCIAL: [Illegible]

FOR THE CHIEF OF EDUCATION: [Illegible]

FOR THE CHIEF OF CULTURE: [Illegible]

FOR THE CHIEF OF RECREATION: [Illegible]

FOR THE CHIEF OF RELIGION: [Illegible]

FOR THE CHIEF OF ARTS: [Illegible]

FOR THE CHIEF OF SCIENCE: [Illegible]

FOR THE CHIEF OF TECHNOLOGY: [Illegible]

FOR THE CHIEF OF ENVIRONMENT: [Illegible]

FOR THE CHIEF OF SPACE: [Illegible]



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-05051

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>LEON WORKMAN</b>			2a. DATE OF DEATH MONTH <b>02</b> DAY <b>22</b> YEAR <b>79</b>			2b. HOUR <b>3:46P</b> M		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>2</b> DAY <b>9</b> YEAR <b>05</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Unkn.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>Unkn.</b> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES COUNTY, MD.</b>		
10. CITY OR TOWN OF DEATH <b>RIVERDALE, MD</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>E. LELAND MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Unkn.</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md.</b>			13b. COUNTY <b>PG</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>7411 Adelphi Road</b>			14. FATHER'S NAME FIRST <b>Unkn.</b> MIDDLE <b>Unkn.</b> LAST <b>Unkn.</b>					
15. MOTHER'S MAIDEN NAME FIRST <b>Unkn.</b> MIDDLE <b>Unkn.</b> LAST <b>Unkn.</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Unkn.</b>					
16b. SOCIAL SECURITY NO. <b>216-03-0142</b>			17. INFORMANT ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ventricular arrhythmia</b> <b>436-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>cerebrovascular accident</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>2 wks</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>2/9</b> 19 <b>79</b> to <b>2/22</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>2/22</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>John R. Melnick MD</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>2/22/79</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>			23b. DATE <b>2/26/79</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>						ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 28 1979</b>
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>								

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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LIVERMORE, 10 E. LEAND HOSPITAL

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										79-05052	
1- STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>HENSEL P. Sinclair Young</b>										2a. DATE KNOWN OF DEATH ESTIMATED <b>2-18-79</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>7-11-07</b>		6. AGE (IN YEARS) <b>71</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2b. HOUR <b>1:20</b> A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES</b> MD.		
10. CITY OR TOWN OF DEATH <b>CLINTON</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <b>SOUTHERN MARYLAND HOSP.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Driver</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Truck</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>PRINCE GEORGES</b>			13c. CITY OR TOWN <b>BRANDYWINE</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William P. Conway Young</b>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eva GREER</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>WW II 217-18-2292</b>			17. INFORMANT <b>6717 Livingston Rd. Philip T. May Oxon Hill, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>ASPHYXIA</b> IMMEDIATE CAUSE (a) <b>911-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>3 (6 P.M.) 2-17-79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>CHOKED ON BOLUS OF MEAT WHILE EATING</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, OR STORE, FARM, ETC.) <b>HOME</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>BOX 99 RT 1, BRANDYWINE, PR. GEORGES, MD 20613</b>					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) <b>DEPUTY</b>				DATE SIGNED <b>2-20-79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>AUGUSTO P. RODRIGUEZ, M.D.</b>				ADDRESS <b>12800 Willow Wind Circle, Tantallon, Md. 20022</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>2-23-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Emmanuel Meth. Cem. Baden, P.G., Maryland</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baden, P.G., Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>WAC DOKE, MD</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 26 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Jeffrey McBrady</i>			

50-02025

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